

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form 100-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>Item 5 Film 0407 12/16/68</div> <div>162708</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>16292</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>										
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH MATED			2b. HOUR	
Robert			E Able			11-14-68 19			5:07pm	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			2d. HOUR	
Male	White	9-16-1962	6 YRS.			11 14 68 19			5:35pm	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U S A				Prince George's Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George Hospital			Student				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
Maryland			Prince George's Forestville			YES <input type="checkbox"/> NO <input type="checkbox"/>			3521 Ashville Road	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Kenneth W. Ruehl			Ida Fugitt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS				
No			--			Kenneth W. Ruehl 3521 Ashville Rd. Forestville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Hemorrhagic shock										
DUE TO, OR AS A CONSEQUENCE OF Laceration of liver and right kidney										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
8124										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			5:05pm 11-14-19 68			Pedestrian struck by car				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
		Ritchie Road 95 ft. North of Ritchie Spur Rd.			Prince George Co., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural Causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			11-15-68				
John Kehoe MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)				
Riverdale, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		11-18-68		Cedar Hill Cemetery			Suitland Pr. Geo. Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE			
Wilhelm Funeral Home 4308 Suitland Rd. S. E. Suitland, Md.				NOV 21 1968						

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 7 & 8 Film 0107
12/3/68 kk
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16293

1. DECEASED NAME (Type or Print) Maude		Middle		Last Adair		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 11-21-68 195:50pm		2b. HOUR	
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH 10-30-1898	6. AGE (In years last birthday) 70 YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.	2c. DATE PRONOUNCED DEAD Month 11 Day 21 Year 68	2d. HOUR 44pm
7a. BIRTHPLACE (State or foreign country) Parrott Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Chapel Oaks		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1412 58th. Avenue.	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 1569 DUE TO, OR AS A CONSEQUENCE OF Carcinoma of bile duct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1551								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH over 6 mo.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe MD		EXAMINER'S NAME (Type) John Kehoe MD		M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 11-22-68	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 11-26-68		23c. NAME OF CEMETERY OR CREMATORY Carver mem		23d. LOCATION (City or Town) Laurel		(County) (State)	
24. FUNERAL DIRECTOR Rollins		ADDRESS 4339-Hunt PK NE		25a. REC'D BY REGISTRAR NOV 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

87301

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16294

1. DECEASED NAME (Type or print) 16230 R. BURTON 2 ROBERT D. ALLISON		2a. DATE OF DEATH Month 11 Day 9 Year 1968		2b. HOUR 3:15 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH 4-10-1905		6. AGE (In years last birthday) 63 YRS.
7a. BIRTHPLACE (State or foreign country) Pa.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George Md.	
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pineview Garden		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.	13b. COUNTY Pr. George	13c. CITY OR TOWN LANDOWNE	13d. INSIDE-CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 7606 Lombard St.
14. FATHER'S NAME First Middle Last WILLIAM ALLISON		15. MOTHER'S MAIDEN NAME First Middle Last MADDIE CAMPBELL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 226-46-9756	17. INFORMANT Address JOANT. CAMPBELL SAME AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4272 DUE TO, OR AS A CONSEQUENCE OF (b) circulatory collapse DUE TO, OR AS A CONSEQUENCE OF (c) pulmonary edema & insufficiency 4-5 hr PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 4330 Emphysema, chronic severe; Asthma				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 10-24, 1968 , to 11-9, 1968 , that (I) (we) last saw the deceased alive on 11-9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Alfred R. Lapin		22c. DATE SIGNED 11-9-68	22d. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN, MD	
22e. ADDRESS CLINTON, MD		22f. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11-12-1968	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL	23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO, RIVERDALE, MD		25a. REC'D BY REGISTRAR DATE NOV 13 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

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16281

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16295

1. DECEASED-NAME (Type or Print)				First Middle Last				2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 11-4-68 19 9:30pm				2b. HOUR			
Mary Jane Barger															
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
Female		White		3-12-1912		56 YRS.						11 4 68 1911:57pm			
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH			
Texas				U S A								Prince George's Md.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly				Prince George Hospital				Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE								13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland								Prince George's		District Heights				7512 Foster Street	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last											
Charles B. Moore				Minnie ? ?											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
No								Conan W. B. Barger				Dist. Hgts. Md. 7512 Foster St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive subarachnoid hemorrhage</u> 4309 DUE TO, OR AS A CONSEQUENCE OF <u>Rupture of Berry aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 330X															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				John Kehoe MD				M.D.				22b. DATE SIGNED 11-5-68			
EXAMINER'S NAME (Type)				John Kehoe MD Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				11-9-68								Prescott Arkansas			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Wilhelm Funeral Home				4308 Suitland Rd. S. E.				DATE NOV 18 1968				Charles Judge			

10581

11-2-68

FOR-STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses, Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16282

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16296

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Florence May Barnes						ESTI- MATED <input checked="" type="checkbox"/> 11-26-68			13:00am M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Female	White	12-16-1988	79	YRS.				Month Day Year 11 26 68			10:00am
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			U.S.A.						Prince George's Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Clinton			8819 Woodyard Road			Homemaker			Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland			Prince George's			Clinton			8819 Woodyard Road		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Henry Hardy			Mary Ellen Boswell								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT					
No			***			8819 Woodyard Road, Mrs. Mary B. Adams, Clinton, Maryland.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4129 DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 10 yrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 4200											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED		
			John Kehoe MD Riverdale, Md.						11-26-68		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			11/29/68			Parklawn Cemetery			Rockville, Montg. Maryland		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
ROBERT A. PUMPHREY, Bethesda, Maryland.			7557 Wisconsin Ave.			DEC 4 1968					

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

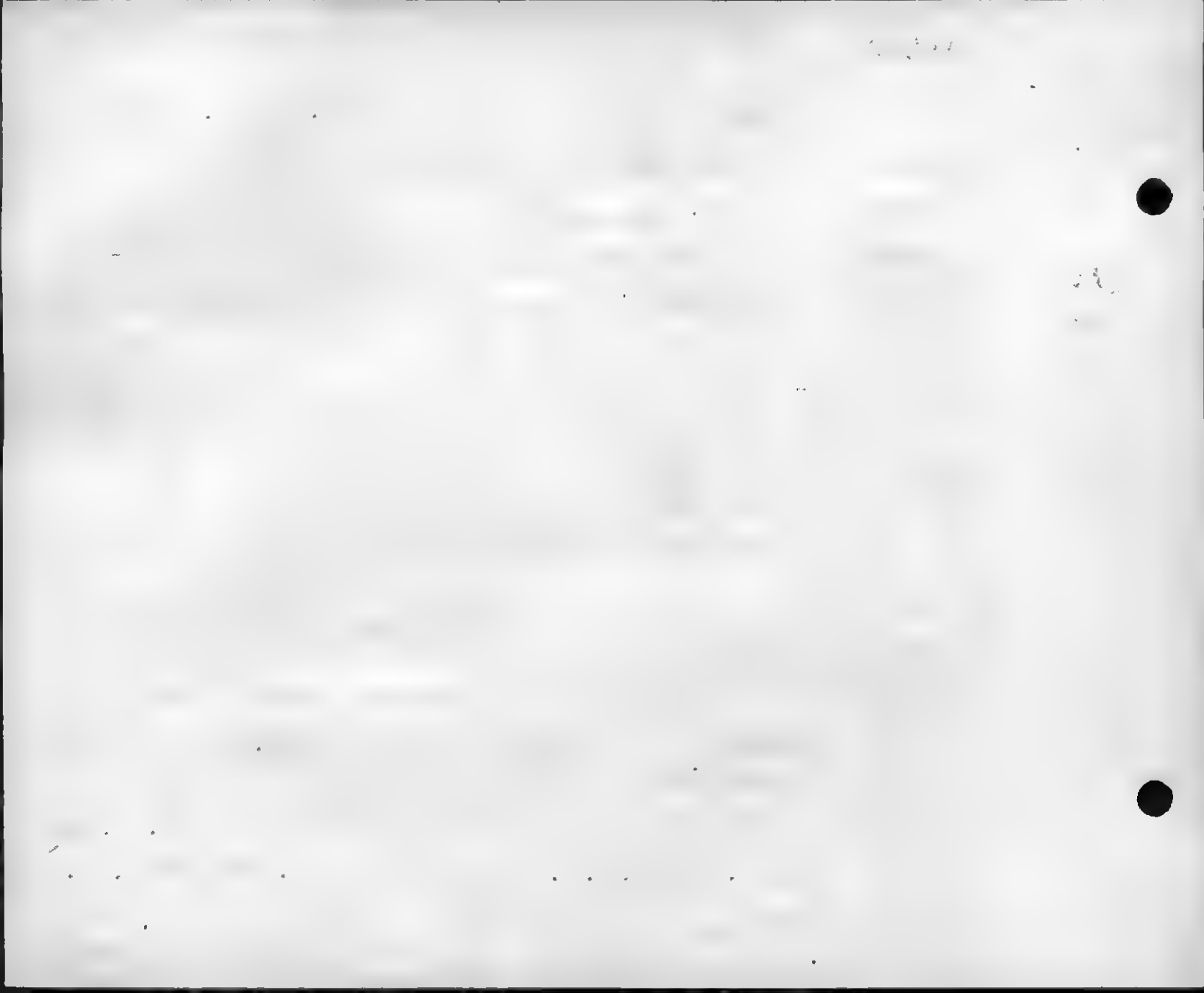
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16283

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16291

1 DECEASED NAME (Type or print) First Middle Last Kathryn Barrett			2a. DATE OF DEATH Month Nov. Day 22 Year 1968		2b. HOUR 7:45AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH 2/27/21		6. AGE (In years last birthday) 47 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Penna.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince George's	13c. CITY OR TOWN Landover Hills	13d. INSIDE CITY LIM. 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 7418 Tilden Street
14. FATHER'S NAME First Middle Last Frank Stillson			15. MOTHER'S MAIDEN NAME First Middle Last Mary ?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 204-01-9813		17 INFORMANT Address David D. Barrett - above address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Exhaustion 18 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Cervix APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Days					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 171x					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. ex. examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Nov. 22, 1968 , to Nov. 22, 1968 , that (I) (xxx) lost saw the deceased alive on Nov. 22, 1968 , and that in (my) (xxx) opinion death occurred on the date and hour and from the causes stated above, (I) (xxx) (did) (xxx) view the body after death.					
22b. SIGNATURE Dayton O. Watkins				22c. DATE SIGNED Nov. 22, 1968	
22d. PHYSICIAN'S NAME (Type) Dayton O. Watkins, M.D.				22e. ADDRESS 5318 Annapolis Rd., Bladensburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/25/68		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cem.	
24. FUNERAL DIRECTOR Nalle's Funeral Home Inc.		ADDRESS Mt. Rainier Maryland		23d. LOCATION (City or Town) (County) (State) Kittanning, Pa.	
25a. REC'D BY REGISTRAR DATE Nov 25 1968				25b. REGISTRAR'S SIGNATURE Charles J. J...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16286		CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print) First Middle Last Annie Roberta Beall			2a DATE OF DEATH Month Day Year Nov. 19, 1968			2b HOUR M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH Mar 17, 1909		6 AGE (n years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Savage Md.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md			
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Iceland Mem. Hospt.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY school			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 205 10th St.	
14. FATHER'S NAME First Middle Last Albert Smith			15. MOTHER'S MAIDEN NAME First Middle Last Edith Bradford						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown		16b. SOCIAL SECURITY NO. no		17. INFORMANT Address Helen Barnard Charles Town Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3509 DUE TO, OR AS A CONSEQUENCE OF (b) After 2 weeks - pneumonia (c) As a result of heart disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 1954, 19, to Nov. 19, 1968, that (I) (we) last saw the deceased alive on Nov. 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert E. King		22c. PHYSICIAN'S NAME (Type) Robert E. King		22d. ADDRESS Laurel, Maryland		22e. DATE SIGNED Nov 19 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-21-68		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cem		23d. LOCATION (City or Town) (County) (State) Colmar Manor Md			
24. FUNERAL DIRECTOR Mary J. H.		25a. REC'D BY REGISTRAR DATE Nov 25 1968		25b. REGISTRAR'S SIGNATURE Robert E. King					

100-100-100

100-100-100

100-100-100



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

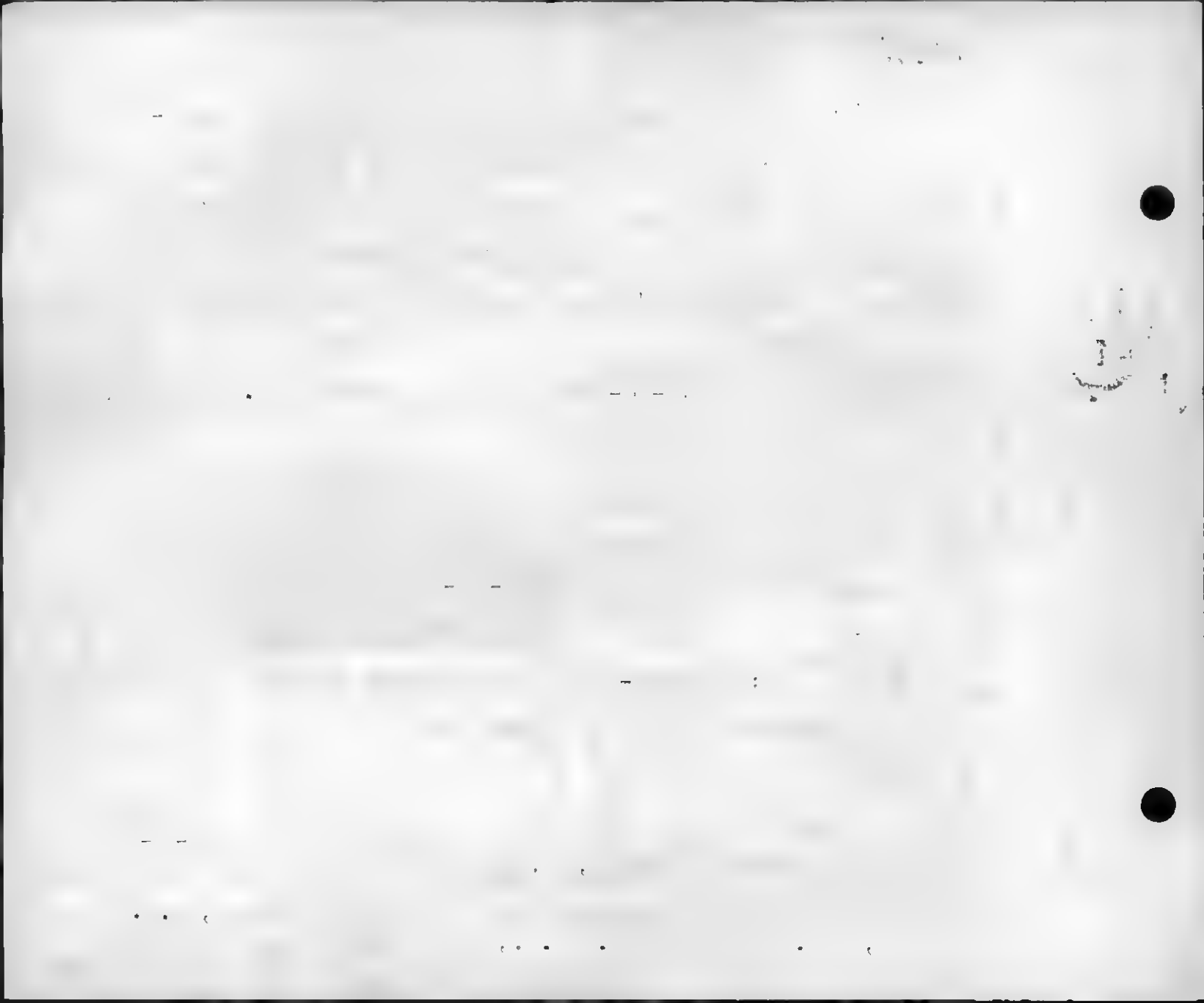
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16285

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16293

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Mary Elizabeth Brown Bell								ESTIMATED DATE MATED		11	12	68	199:30am
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	Negro	9-12-1894		74 YRS		MONTHS DAYS		HOURS MIN		Month Day Year		68 199:30am M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Maryland		USA				Prince George's		Md					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				2b. KIND OF BUSINESS OR INDUSTRY	
Riverdale				Leland Memorial Hospital				Housewife					
13a. U.S.A. RESIDENCE (Where deceased lived, if institution, residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland				Prince George's				Upper Marlboro				RFD Box 2105	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Unknown				Unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT				ADDRESS	
No				218-30-4079A				Hilda Diggs				Upper RFD Bx. 2105 Marlboro	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY.													
IMMEDIATE CAUSE (a) Cardiac arrest												minutes	
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease												unknown	
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
Fracture neck of left femur - 10-14-68													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
10-17-68				Fracture neck of left femur				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
CAUSE OF DEATH				4:20am 10-14-19 68				Fell in bedroom of home					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or RFD No City or Town County State					
				Bedroom of home				same as #13					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED	
EXAMINER'S NAME (Type)								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				11-13-68	
John Kehoe MD				Riverdale, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
ADDRESS								ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				11/16/68		Mount Olivet				Washington, D.C.			
24. FUNERAL DIRECTOR				25a. REC'D BY REG STRAR				25b. REGISTRAR'S SIGNATURE					
Rollins, Inc. 4339 Hunt Pl., N.E., DC				NOV 14 1968				f Charles Judge					



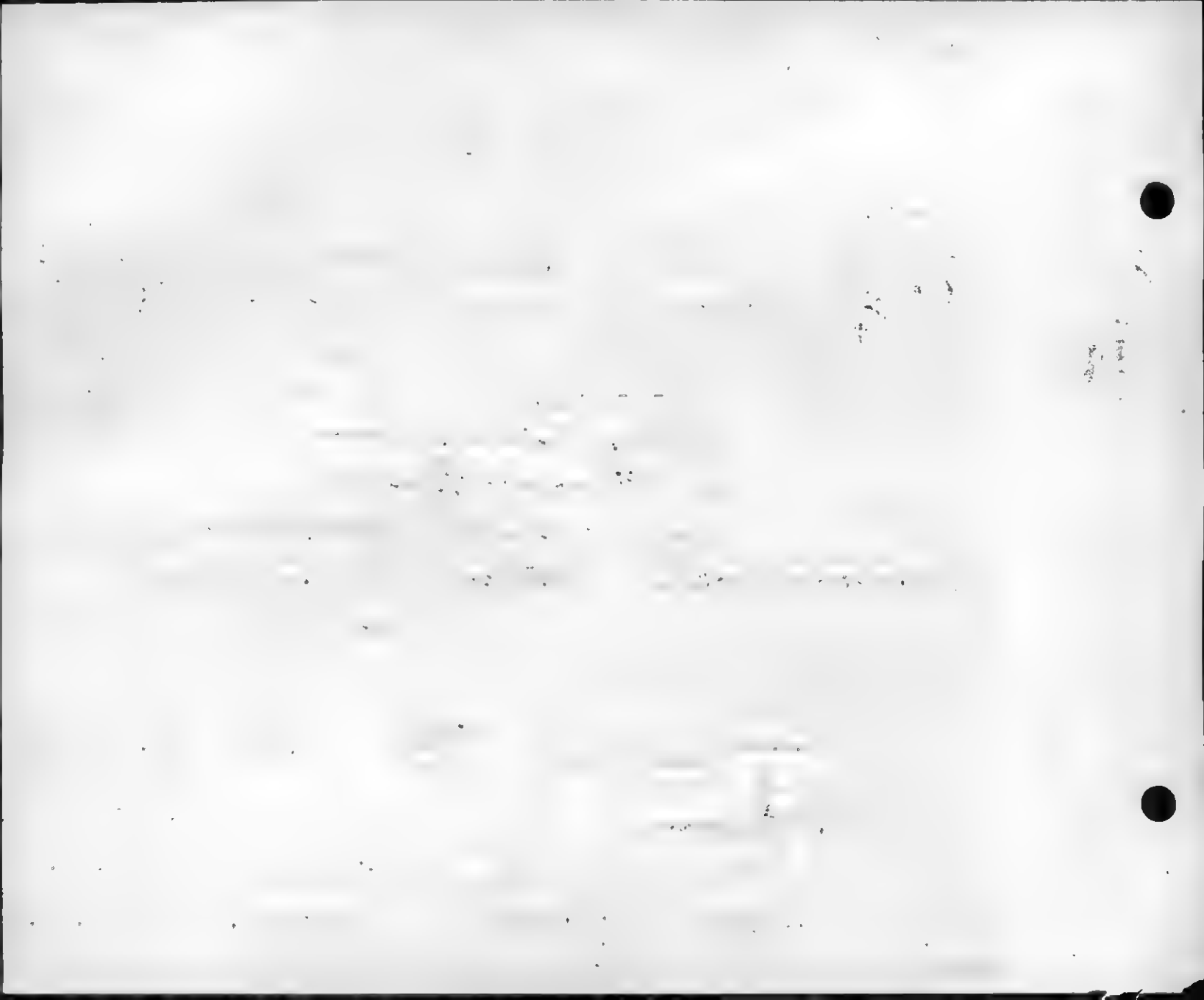
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

16286

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1998

1. DECEASED NAME (Type or print) Herbert		First O.		Middle Benson		Last 11		20. DATE OF DEATH Month 18 Day 68 Year 10:10a			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 6-16-92		6. AGE (In years last birthday) 76 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George		Md			
10. CITY OR TOWN OF DEATH College Park		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 4526 Albion Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Standard Oil (Retired)		12b. KIND OF BUSINESS OR INDUSTRY News		Washington		Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Res. den. before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4526 Albion Rd.		College Park	
14. FATHER'S NAME First Alfred Middle Benson Last Bennett		15. MOTHER'S MAIDEN NAME First Sarah Middle Bennett Last Bennett									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 182-22-8666		17. INFORMANT Medical Records Department		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF Ac Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Heart Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Carcinoma Prostate - metastatic to Urinary Bladder											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Nov 15, 1966 , to Nov 18, 1968 , that (I) (we) last saw the deceased alive on Nov 15, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. Etienne		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11-18-68					
22d. PHYSICIAN'S NAME (Type) W. Etienne, M.D.		22e. ADDRESS 4713 Berwyn Rd., College Park, Md.									
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/21/68		23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin Co., Pa.					
24. FUNERAL DIRECTOR Walter J. Grove		ADDRESS Waynesboro		25a. REC'D BY REGISTRAR DATE NOV 21 1968		25b. REGISTRAR'S SIGNATURE Charles George					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 23 Film 0407
12/3/68 kk

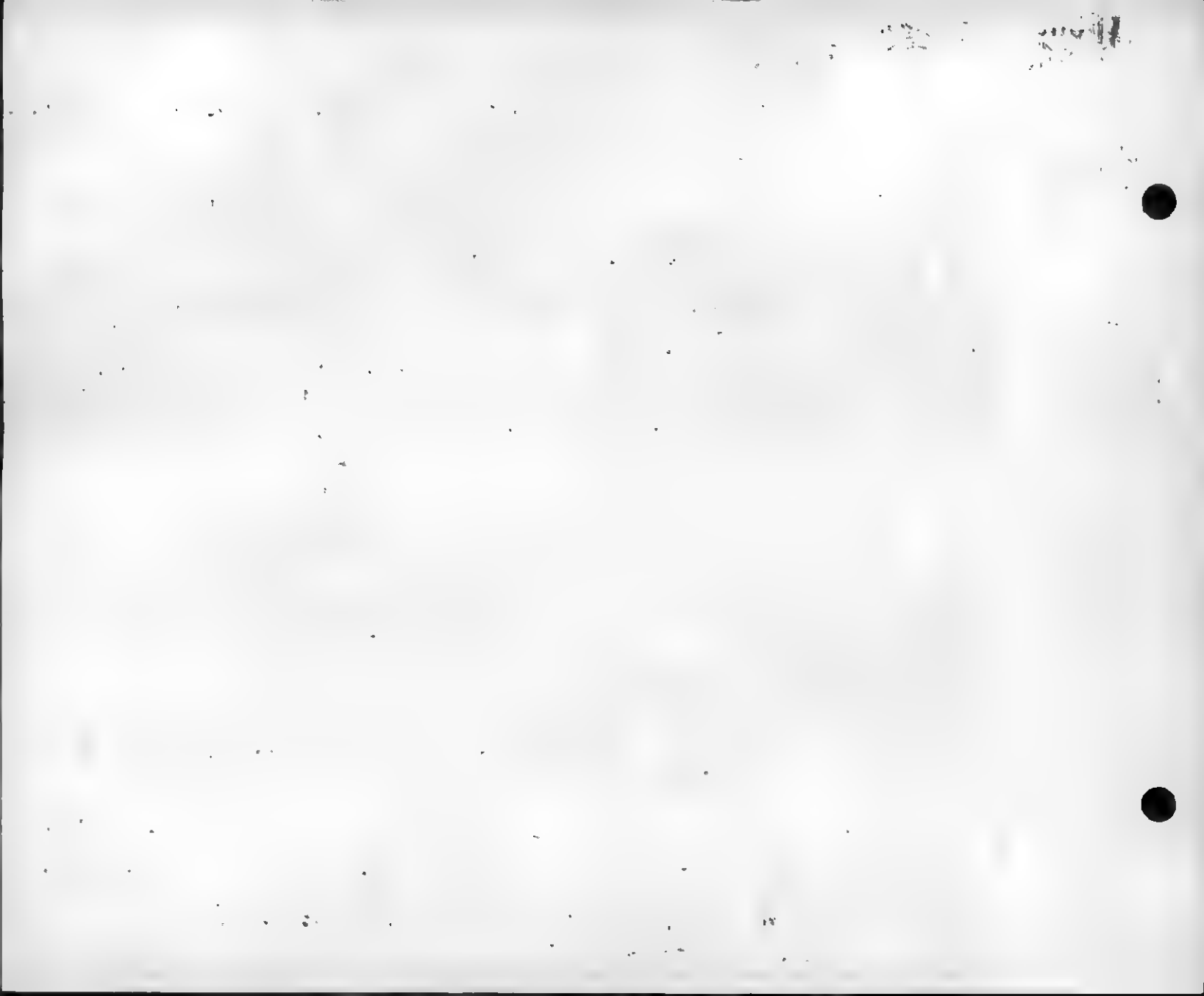
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16287

CERTIFICATE OF DEATH

1630

1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH				2b. HOUR			
Burt						Black		Nov. 19, 1968				6 A. M.			
3 SEX		4. RACE		5. DATE OF BIRTH				6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		Negro		July 22, 1914				54 YRS.		MONTHS		DAYS			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.			
So. Car.		USA		Prince George's											
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY			
Cheverly				Prince Geo. Gen'l Hospital											
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. CITY				13c. CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Maryland				Prince George's				Cedar Hgts.		YES <input type="checkbox"/> NO <input type="checkbox"/>		6409 K Street			
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				First	
Warren								Black		Ellis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17. INFORMANT		Address					
						578-10-6483		Daughter Queen E Davell		1218 H St. NW Wash D.C.					
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic Carcinoma, right lung, with metastasis.															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
16d1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21b. PLACE OF INJURY (At home farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from Nov. 13, 1968, to Nov. 19, 1968, that (I) (we) last saw the deceased alive on Nov. 19, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death															
22b SIGNATURE															
22d. PHYSICIAN'S NAME (Type) Joselito Magday, M. D.															
22e. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)		(County) (State)			
				23 Nov. 68		Harmon Mem. Cemetery				Landover		Md			
24. FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
379				L & Langford 611 K St NW				DATE NOV 20 1968		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1-68

16283										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										1630									
CERTIFICATE OF DEATH																													
1. DECEASED NAME (Type or print)					First Middle Last Lillian B Blaisdell					2a. DATE OF DEATH Month Day Year Nov 15, 1968					2b. HOUR 1:45 AM														
3. SEX female					4. RACE white					5. DATE OF BIRTH Sept 19, 1868					6. AGE (In years last birthday) 100 YRS					7. IF UNDER 1 YEAR MONTHS DAYS					8. IF UNDER 24 HRS. HOURS MIN				
7a. BIRTHPLACE (State or foreign country) Massachusetts					7b. CITIZEN OF WHAT COUNTRY? U S A					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Pro Georges Md														
10. CITY OR TOWN OF DEATH Adelphi					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hill Haven rest home					12a. USUAL OCCUPATION (Kind of work done during most of work no life, even if retired.) Retired					12b. KIND OF BUSINESS OR INDUSTRY Export Co														
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md					13b. COUNTY Pro Geo					13c. CITY OR TOWN Cheverly					13d. INSIDE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 6204 Lombard st									
14. FATHER'S NAME First Middle Last John W Blaisdell					15. MOTHER'S MAIDEN NAME First Middle Last Emily Deering																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)					16b. SOCIAL SECURITY NO					17. INFORMANT Address Wm W Blaisdell Cheverly, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 4129 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) anemia, azotemia																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from Nov 14, 1968, to Nov 15, 1968, that (I) (we) last saw the deceased alive on Nov 14, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE J. B. Cameron DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED Nov 16, 1968														
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation					23b. DATE Nov 15, 1968					23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory					23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.														
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.										25a. REC'D BY REGISTRAR DATE NOV 18 1968					25b. REGISTRAR'S SIGNATURE J. Charles Judge														

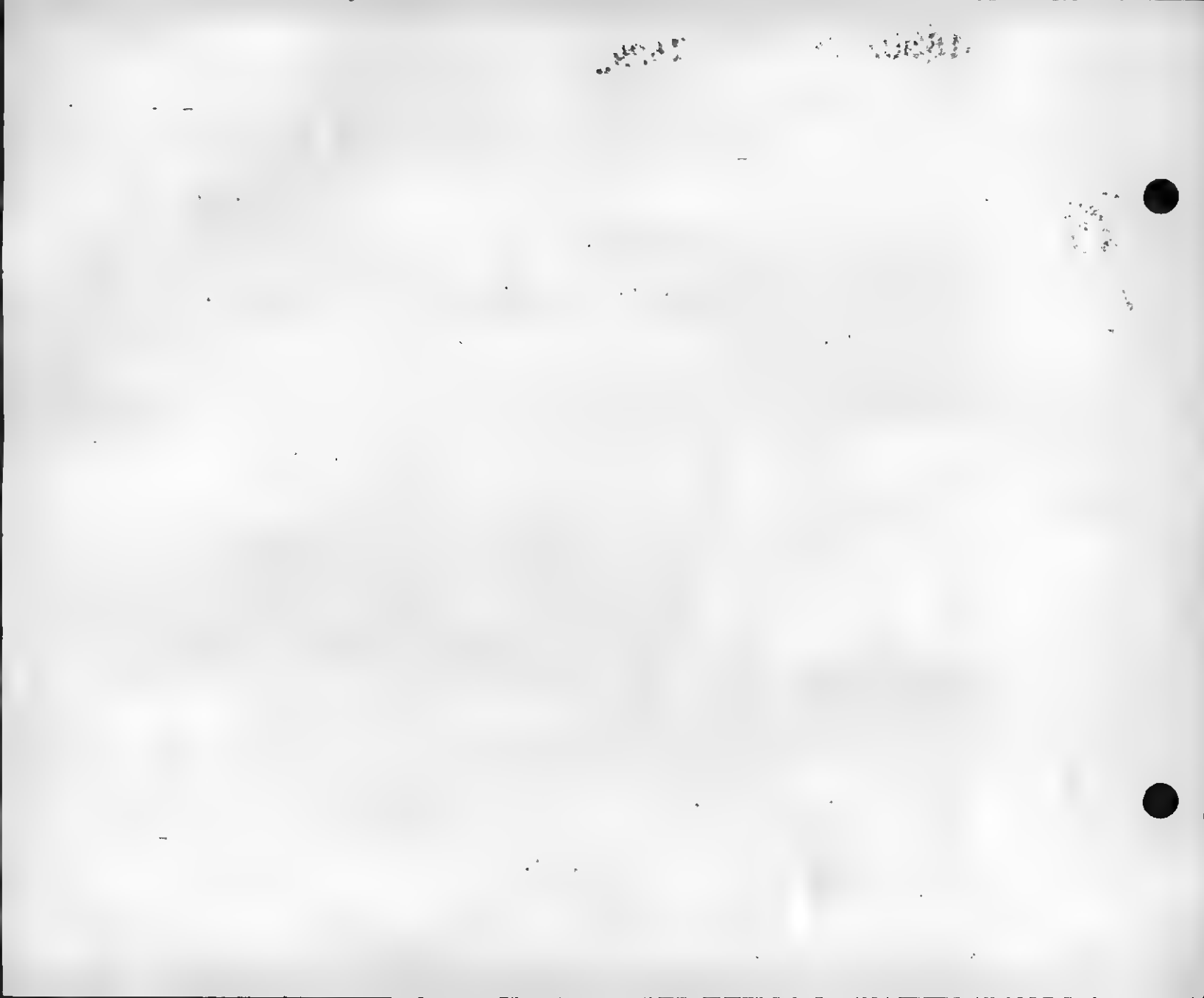


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Section 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

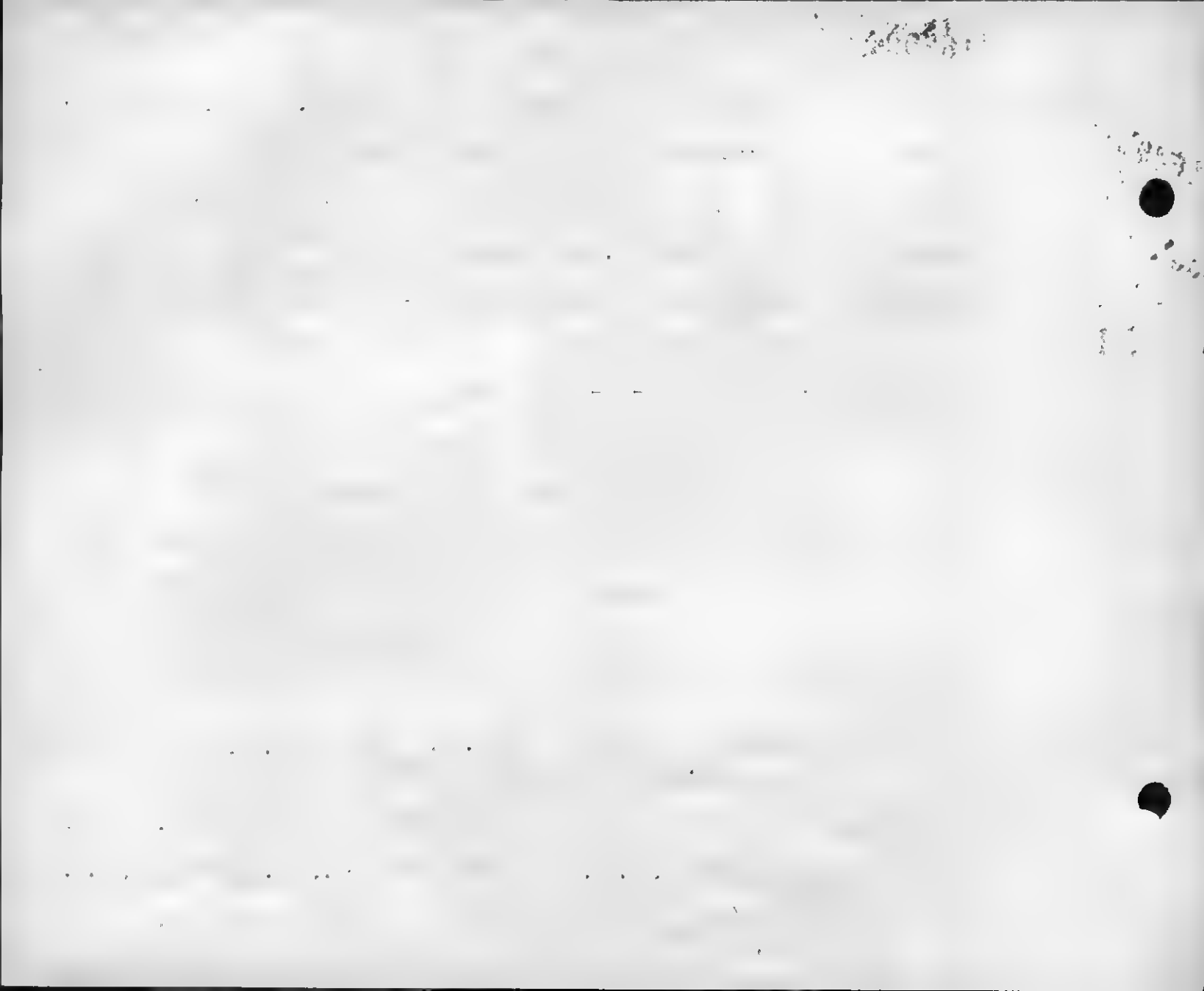
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI-DEATH MATED			2b HOUR
Joseph			Bowie			11-16-68 19 9			50pm
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year	
Male	Negro	6-7-1877	91 YRS.					11 16 68 19 10:15pm	
7a BIRTH-PLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pr. Geo. Co. Md.		U.S.A.				Prince George's Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Clinton			Clinton Medical Center						
13a USUAL RESIDENCE (Where deceased lived, if institution Res. since before admission) STATE			13b CITY OR TOWN			13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER
Maryland			Prince George's Camp Springs						7057 Allentown Road
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Bowie, John H.			Mary E. Bruce						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS			
						Roland A. Bowie - Same as above			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 1 yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4 LDC</u>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State				
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED			
EXAMINER'S NAME (Type)			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			11-17-68			
John Kehoe MD Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial			Nov. 20/68		St. John's Church Cem.		Clinton, Pr. Geo. Md.		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Marcell Adams Aquasco, Md.						NOV 25 1968		[Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16290 CERTIFICATE OF DEATH 16304									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Laura M. Bowman						Nov. Month 8, Day 1968			6:45A M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		Caucasian		March 8, 1887			81 YRS		11 UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			10. CITY OR TOWN OF DEATH
Virginia		U.S.A.				Prince George's Md			Cheverly
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Prince Geo. Gen'l Hospital									
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Prince George's		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5802 42nd Avenue
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Jacob Boehm			Cathern Copeland						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address (above address)		
No			578-56-7515		Roberta L. Bowman				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>									3 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first									
(b) <u>Chronic Coronary Arteriosclerosis</u>									2 years
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Chronic Coronary Arteriosclerosis</u>									4 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4. <u>Chronic Coronary Arteriosclerosis (S. P. A. C. A.)</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			19 P.M.						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) <u>(husband)</u> attended the deceased from <u>Nov. 4, 1968</u> to <u>Nov. 8, 1968</u> , that (I) <u>last</u> saw the deceased alive on <u>Nov. 8, 1968</u> , and that in (my) <u>(husband)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(husband)</u> did <u>not</u> view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
<u>Saul Schwartzbach, M.D.</u>								Nov. 8, 1968	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
Saul Schwartzbach, M.D.			106 Irving St., NW. Washington, D.C.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		11/11/68		Massanutten Cem.		Woodstock, Va.			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Halle's Funeral Home Inc., Maryland			DATE NOV 14 1968			Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be returned for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 13a-22a Film 409 Maryland STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI-DEATH MATED			2b HOUR		
Regina Dawn Bradley						11-17-68 197			00am		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD			2d HOUR
Female	White	8-27-1968	YRS 2	21				11 17 68			10:00am
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
W. Va.		U S A				Prince George's Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Maryland			Prince George's			Suitland			YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e STREET AND NUMBER					
Joe E. Bradley			Norma Shaver			4656 Homer Avenue					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			--			Joe A. Bradley			4656 Homer Ave.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>SPILL</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>SPILL</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		19 P.M.									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED			
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				11-18-68			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		11-20-68		Bradley Cemetery		Lindside W. Va.					
24 FUNERAL DIRECTOR				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE			
Wilhelm Funeral Home 1308 Suitland Rd. 3. E.				MAY 21 1968							

(17.3)

20.3



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16292

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10800

1. DECEASED-NAME (Type or Print)			First Allen			Middle Eugene			Last Bridges			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 11-6-68 19 5:30pm			2b. HOUR																				
3 SEX Male		4 RACE White		5 DATE OF BIRTH 12-11-1931		6 AGE (In years last birthday) 36 YRS		IF UNDER 1 YEAR MONTHS 11		IF UNDER 24 HRS DAYS 6		HOURS 68		MIN 17:00		2c. DATE PRONOUNCED DEAD Month 11 Day 6 Year 1968		2d. HOUR																	
7a. BIRTHPLACE (State or foreign country) North Carolina				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Prince George's Md																							
10. CITY OR TOWN OF DEATH Bladensburg				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4205 57th. Avenue								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Policeman				12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE North Carolina				13b. COUNTY Dallas				3c. CITY OR TOWN Dallas				3d. INSIDE CITY (Y/N)? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Rt. 1, Box 492																					
14. FATHER'S NAME First Odell Bridges						Middle 						Last 						15. MOTHER'S MAIDEN NAME First Mary Lee Jenkins						Middle 						Last 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16b. SOCIAL SECURITY NO (If yes give war or dates of service) 241-46-1647						17. INFORMANT Patricia Lynne Bridges (wife)						ADDRESS																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of head DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 155X PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 176X																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 3:30pm P.M. 11-6-19 68						21b. TIME OF INJURY Month, Day, Year HOUR A.M. 11-6-19 68						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Shot self in head with Cal. revolver.																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 4205 57th. Avenue, Bladensburg, Prince George Co., Maryland						21f. LOCATION Street or R.F.D. No City or Town County State																							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion on death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																																			
ACTUAL SIGNATURE John Kehoe						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED 11-7-68																							
EXAMINER'S NAME (Type) John Kehoe MD						M.D. Riverdale, Md.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																							
												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																							
												ADDRESS (Street, city, town, or county) 																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 11/9/68				23c. NAME OF CEMETERY OR CREMATORY Hollywood				23d. LOCATION (City or Town) (County) (State) Castonia, North Carolina																							
24. FUNERAL DIRECTOR Wash. Metro Funeral Service						Box 1195 Falls Church, Va.						25a. REC'D BY REGISTRAR NOV 14 1968				25b. REGISTRAR'S SIGNATURE g Charles Judge																			

1901

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

16292

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16301

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH ESTIMATED			2b HOUR		
John W Brooks						11-16-68 194:30pm					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	2c DATE PRONOUNCED DEAD			2d HOUR		
Male	Negro	3-4-1891	77 YRS			11 16 68 95:15pm			M		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
West Va.			USA						Prince George's Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Glenn Dale			Glenn Dale Hospital								
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b CITY OR TOWN			13c INSIDE CITY LIMITS?			13e STREET AND NUMBER		
District of Columbia			Washington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			5040 Lee Street N.E.		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
Peter Brooks Louise			Willis								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS		
No						Leo Brooks - same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral hemothorax</u> DUE TO, OR AS A CONSEQUENCE OF <u>Multiple rib fractures</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			4:30pm 19			Fell out 3rd. story window					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
			Glenn Dale Hospital, Glenn Dale, Prince George County, Maryland								
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						11-17-68		
John Kehoe MD Riverdale, Md.			ADDRESS (Street, city, town, or county)								
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
			11-21-1968			Mt Olivet Cem			Bladensburg Rd N.C.		
24 FUNERAL DIRECTOR			ADDRESS			25a REG'D BUREAU DATE			25b REGISTRAR'S SIGNATURE		
Henry S. Washington & Sons-4925-Denver St.						NOV 25 1968					

18, 1901

474

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15
45M - 1

<div>16294</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>16304</div>																												
1 DECEASED-NAME (Type or print)			First Annie		Middle J.		Last Brown		2a. DATE OF DEATH Month Nov.		Day 26		Year 1968		2b. HOUR P. 6:15		M. M											
3 SEX Female			4 RACE Colored			5 DATE OF BIRTH 11/22/76			6 AGE (In years last birthday) 92 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN													
7a BIRTHPLACE (State or foreign (County) Prince Geo. Md.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md																			
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's General						12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY															
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b CITY Pr. Geo's.			13c CITY OR TOWN Naylor			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER Box 3693																
14 FATHER'S NAME First George						Middle Middleton						Last Dotson																
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, at unknown			16b SOCIAL SECURITY NO 214-58-2308			17 INFORMANT Ruth Harper			Address 1406 Brooks Rd.			Wash. D.C. S.E.																
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) - Cardiac Arrest -																												
DUE TO, OR AS A CONSEQUENCE OF (b) Malnutrition, dehydration																												
DUE TO, OR AS A CONSEQUENCE OF (c) CVA - which made good antedote infusible																												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CVA																												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)						21f LOCATION Street or R.F.D. No			City or town			County			State										
22a. I certify that (i) (this hospital) attended the deceased from 10/21, 1968, to 11/26, 1968, that (i) (we) last saw the deceased alive on 11/26, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death																												
22b SIGNATURE Dr. V. Nair, M.D.																		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) Dr. V. Nair, M.D.																		22e. ADDRESS Pr. Geo. Gen Hosp. Cheverly, Md. !										
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE 11-30-68			23c NAME OF CEMETERY OR CREMATORY Notttingham - Creome Cem.			23d LOCATION (City or town) Naylor - Pr. Geo. Co. Md.			(County)			(State)													
24 FUNERAL DIRECTOR Mantell Adams			ADDRESS Ligwasso, Md.						25a REC'D BY REGISTRAR DATE DEC 3 1968			25b REGISTRAR'S SIGNATURE Charles Judge																

807-1381

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1

16295

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16307

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Irving Middle F. Last Brown			2a. DATE OF DEATH Month 11 Day 25 Year 68			2b. HOUR 4:15 PM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 7/8/21		6. AGE (in years lost birthday) 47 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Prince George's County, Md. Md.	
10. CITY OR TOWN OF DEATH Glenn Dale			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Law Clerk	
12b. KIND OF BUSINESS OR INDUSTRY --			13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE DC			13b. COUNTY Washington	
13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 815 5th Street, N. W.	
14. FATHER'S NAME First Dorsey Middle Brown Last Brown			15. MOTHER'S MAIDEN NAME First Daisey Middle Gregg Last Gregg				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) yes 1943-1949			16b. SOCIAL SECURITY NO 579-16-0936		17. INFORMANT Decedent		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure acute and chronic 011.2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Pulmonary tuberculosis, far advanced, active (b) 17 years (c) 17 years							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Right pneumonectomy, 1960, with bronchopleural cutaneous fistula							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/2/ , 19 66 , to 11/25 , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/25/ 19 68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (d d) (do not) view the body after death.							
22b. SIGNATURE Mac Weiss, M.D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/25/68	
22d. PHYSICIAN'S NAME (Type) Mac Weiss, M.D.				22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Nov. 28, 1968		23c. NAME OF CEMETERY OR CREMATORY Mt. View		23d. LOCATION (City or Town) (County) (State) Purdum, Md.	
24. FUNERAL DIRECTOR Olin L. Nolesworth, Damascus, Md.				25a. REC'D BY REGISTRAR DEC 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

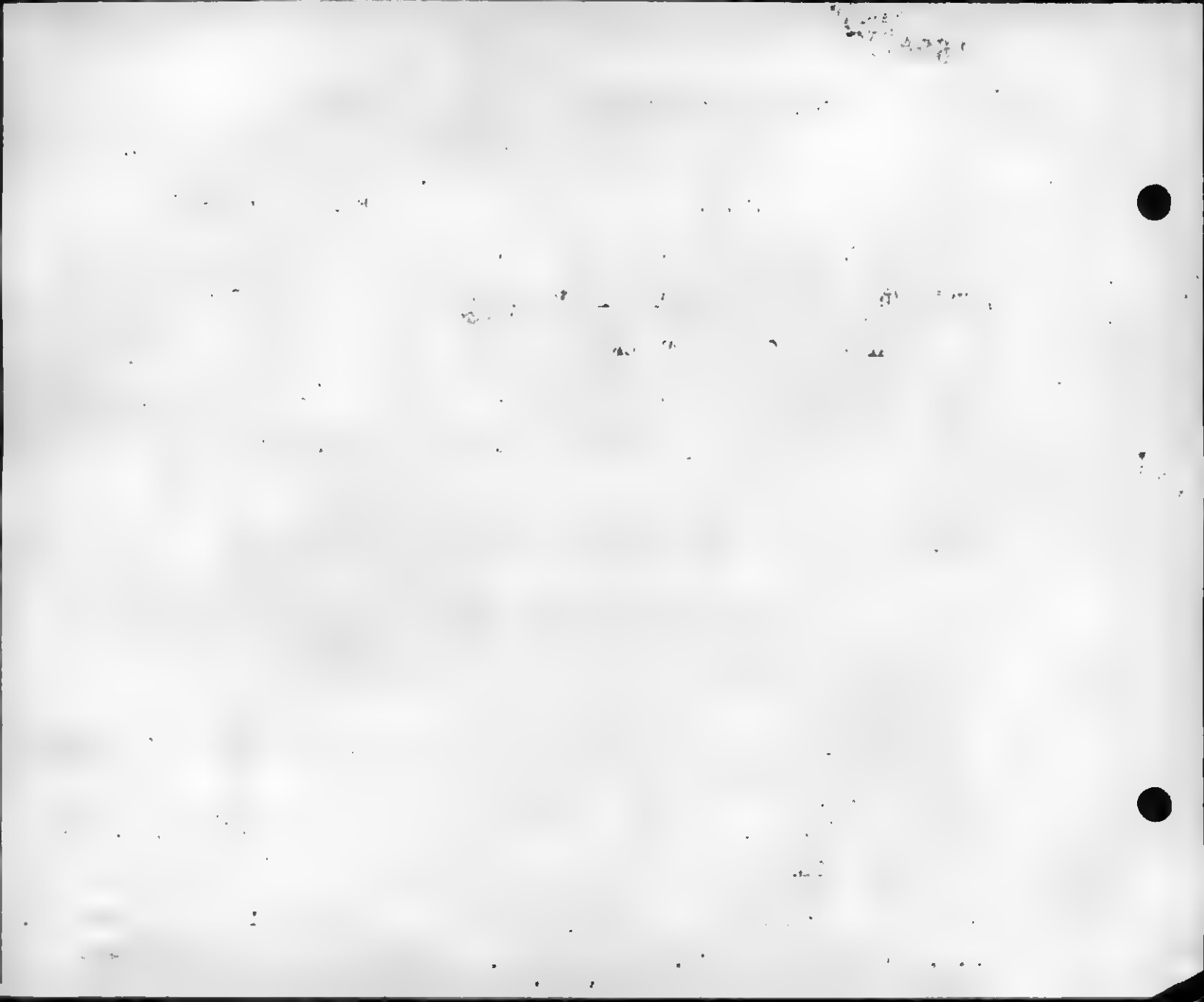
VR 151-1
30M REV. 7/68

16296

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16511

1 DECEASED NAME (Type or print) STEVEN COURTENAY BROWNE			2a DATE OF DEATH Nov Month 29 Day 68 Year			2b HOUR 7:08 M	
3 SEX MALE		4 RACE CAUC		5. DATE OF BIRTH 5 OCT 68		6 AGE (In years last birthday) YRS. 1 MONTHS 4 DAYS	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES Md	
10 CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAFHOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NA		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. CITY OR TOWN PRINCE GEORGES FORESTVILLE		13c INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 4425 RENA RD APT 102	
14. FATHER'S NAME First Middle Last WALTER COURTEWAY BROWNE			15 MOTHER'S MAIDEN NAME First Middle Last PATRICIA JEAN ROBINSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. NA		17 INFORMANT Address Father Same as item #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration, terminal of gastric contents 911 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 921.9							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (he)(this hospital) attended the deceased from 11-29, 1968 , to 11-29, 1968 , that (I) (we) last saw the deceased alive on 11-29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE John Goodman M.D.						22c DATE SIGNED 29 Nov. 68	
22d. PHYSICIAN'S NAME (Print) JOHN GOODMAN				22e ADDRESS MALCOLM GROW USAFHOSP.			
23a BURIAL, CREMATION, REMOVA. (Specify) Burial		23b. DATE 12-2-68		23c NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City or Town) (County) (State) Pikesville Balto. Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.				25a. REC'D BY REGISTRAR DATE DEC 2 1968		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

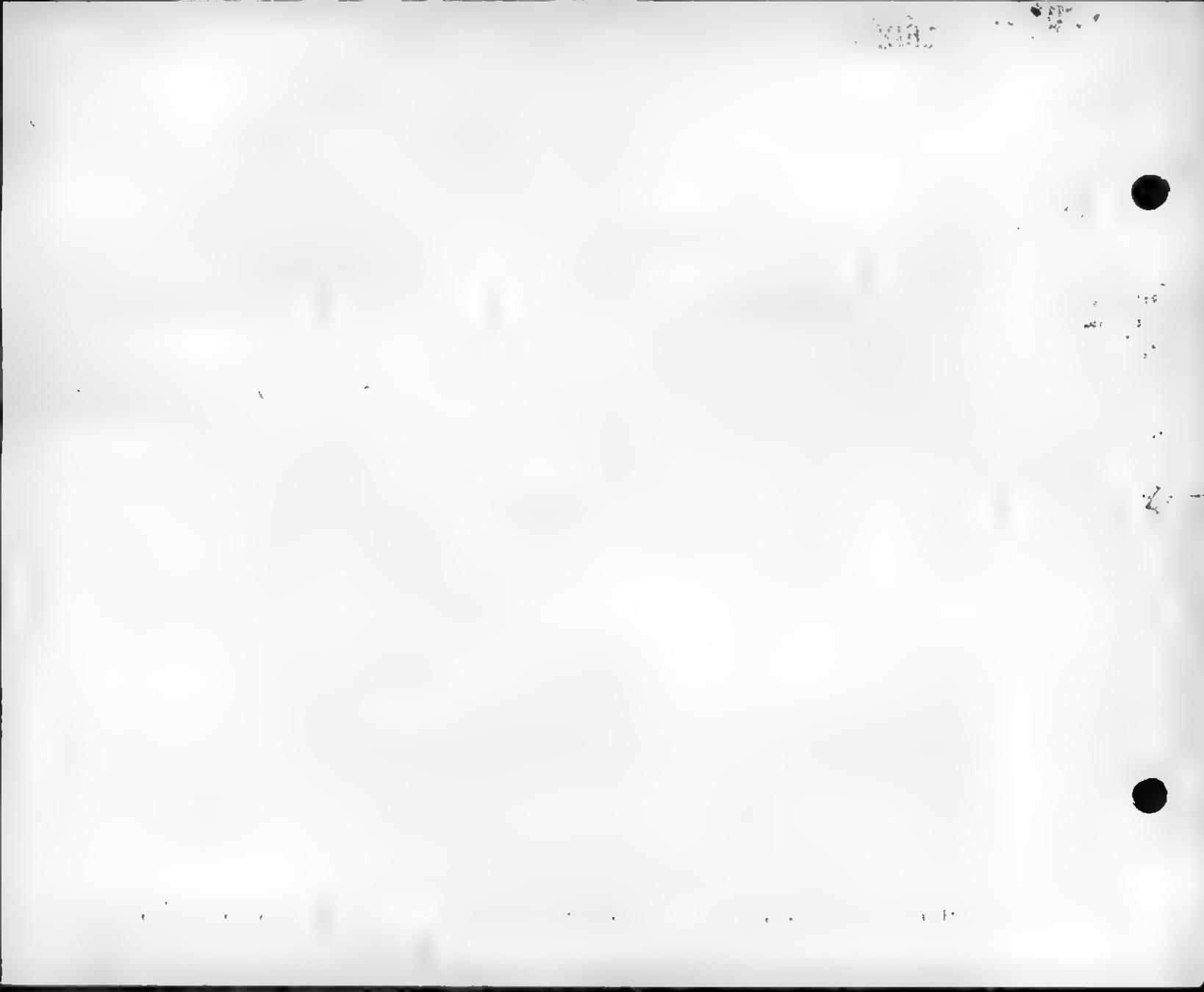
16297

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1631

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last CARRIE F BUCKLER			2a. DATE OF DEATH Month Day Year 11 1 68			2b. HOUR Min 4:20		
3 SEX Female		4 RACE white		5 DATE OF BIRTH 10/8/91		6. AGE (In years last birthday) 77		
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? US		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH P. Gees.		
10 CITY OR TOWN OF DEATH CLINTON MD			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PIERVIEW GARDENS			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MD COUNTY CLAY PVE NURSING HOME			13c. CITY OR TOWN MD		13d. INSIDE CITY (LM 157) YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12C. FRASER Rd	
14. FATHER'S NAME First Middle Last JAMES QUADE			15. MOTHER'S MAIDEN NAME First Middle Last JANE M. LACEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOC. SEC. SECURITY NO. 214-12-8777D		17 INFORMANT Name Address Mildred Hodges (Daughter)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse 4119 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus & debility APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 Days								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) H								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b. SIGNATURE Alfred R. Lapin		DEGREE ALFRED R. LAPIN, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN, M.D.		22e. ADDRESS CLINTON, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Nov. 4, 1968		23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPHS		23d. LOCATION (City or Town) (County) (State) MORGANZA, ST. MARY'S, MARYLAND		
24 FUNERAL DIRECTOR ADDRESS W. Clarke Mattingly, C.M.				25a. REC'D BY REG. STR. DATE NOV 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil on Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16298

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
John Joseph Buckley						DATE MATED <input checked="" type="checkbox"/> 11-27-68			198:48am		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD			2d HOUR
Male	White	3-20-1897	71 YRS					11 Month 27 Day 68 Year			54am M
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Connecticut			U S A						Prince George's Md		
1d CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Retired engineer			U S Gov't		
13a USUAL RESIDENCE (Where deceased lived, if not in institution, residence before admission)			13b CITY OR TOWN			13c INSIDE CITY LIMITS?			13d STREET AND NUMBER		
Maryland Prince George's Cheverly						YES <input type="checkbox"/> NO <input type="checkbox"/>			5397 Quincy St. Apt. #1		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
John J Buckley sr			Margaret M Fitzgerald								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> W W I			216 41 3117			Mary M Cochran			Cheverly, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 7 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED		
John Kehoe MD			Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			11-27-68		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			Nov 30, 1968			Mt Olivet Cemetery			Washington D. C.		
24 FUNERAL DIRECTOR						ADDRESS			25a REC'D BY REGISTRAR		
F. Gasch's Sons Hyattsville, Md.									25b REGISTRAR'S SIGNATURE		
						DATE DEC 2 1968			Charles Judge		

100-1000



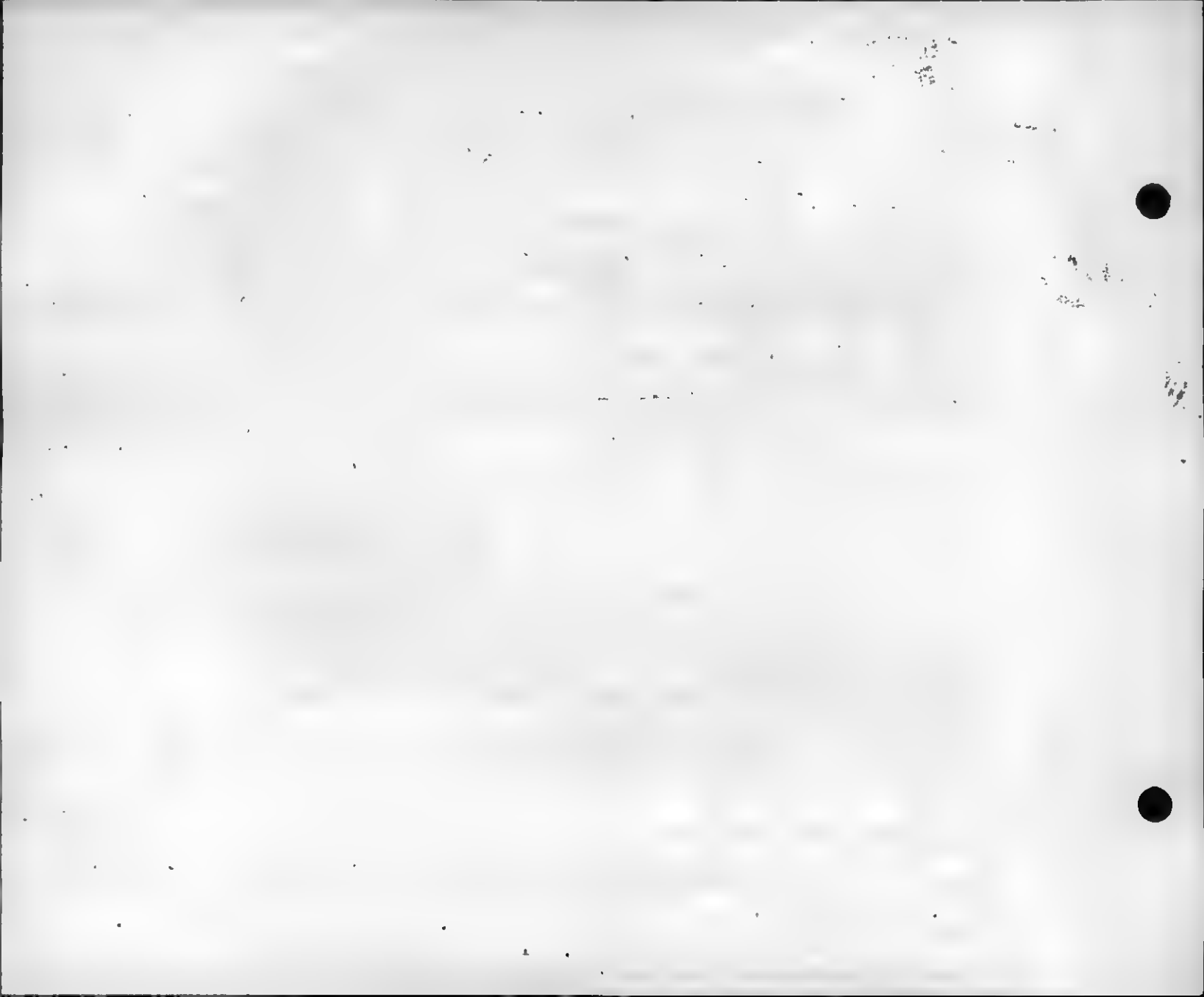
16299

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>John</i>		First <i>John</i>		Middle <i>W.</i>		Last <i>Bush</i>		2a. DATE OF DEATH Month <i>November</i> Day <i>18</i> Year <i>1968</i>		2b. HOUR <i>10 A M</i>	
3. SEX <i>male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>6/22/1893</i>				6. AGE (In years lost birthday) <i>75 yrs</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Dash., D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George's</i>					
10. CITY OR TOWN OF DEATH <i>MT Rainier</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>3001 Shepherd</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Ret. - Pullman Co.</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Prince George's</i>		13c. CITY OR TOWN <i>MT Rainier</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3001 Shepherd Street</i>			
14. FATHER'S NAME First <i>John</i> Middle <i>W.</i> Last <i>Bush</i>		15. MOTHER'S MAIDEN NAME First <i>Ellen</i> Middle <i>O'Prey</i> Last <i>-</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service) <i>None</i>							
16b. SOCIAL SECURITY NO <i>709-02-0877</i>		17. INFORMANT <i>Elizabeth R. Bush</i> Address <i>above address</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive myocardial infarction</i> (Wife) <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>occasional hypertensive state</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>-</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 1/2 years</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>none</i>											
19a. DATE OF OPERATION <i>7-1</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>none</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb</i> , 1968, to <i>Nov 16</i> , 1968, that (I) (we) lost saw the deceased alive on <i>Nov 16</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Frank R. Shea M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>Nov 18, 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>FRANK R. SHEA</i>		22e. ADDRESS <i>4100-22nd NE D.C. 20018</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11/21/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Colmar Manor, Md.</i>					
24. FUNERAL DIRECTOR <i>Nalley's Funeral Home Inc.</i>		ADDRESS <i>MT Rainier, Maryland</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 25 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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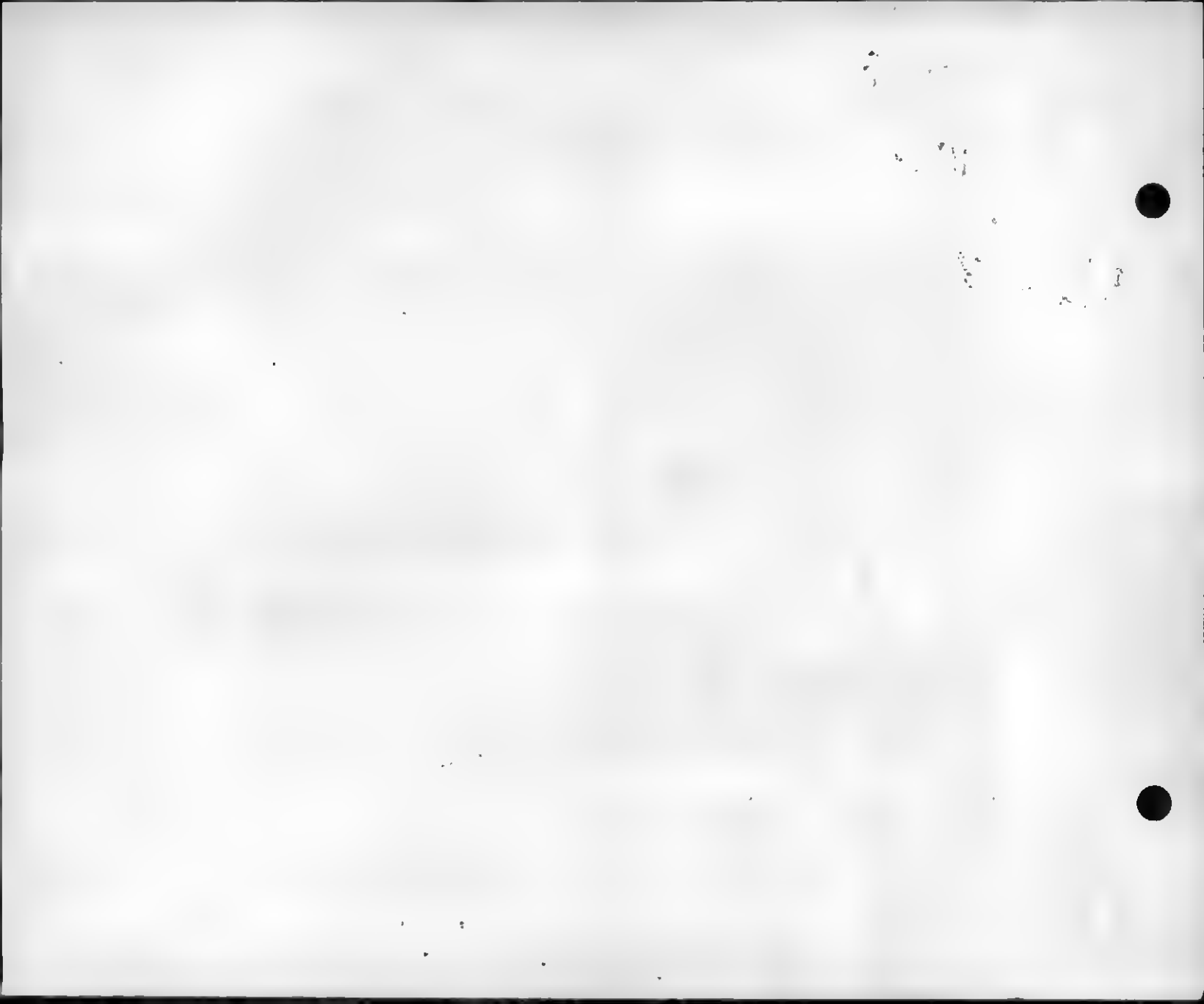
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16300

CERTIFICATE OF DEATH

16311

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Morningside</u>		c. LENGTH OF STAY IN 1b <u></u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		d. STREET ADDRESS <u>222 Woodland Road</u>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH W. CALDWELL</u>		4. DATE OF DEATH Month <u>11</u> Day <u>20</u> Year <u>1968</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 30, 1906</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager Auto Body Shop</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State or foreign country) <u>Washington D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Caldwell</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Mahoney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>18</u>	
17. INFORMANT <u>Alberta A. Caldwell</u>		Address <u>222 Woodland Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Bladder with</u> DUE TO <u>Metastases to Lungs, Mediastinum & Brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>10</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Oct</u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 5, 1968</u> to <u>Nov 20, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov 18, 1968</u> , and that death occurred at <u>9P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John F. Shay</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>11-20-68</u>
22c. PHYSICIAN'S NAME (Type) <u>JOHN F. SHAY</u>		22d. ADDRESS <u>5509 Old Silver Hill Rd, Suitland Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-23-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Wilhelm Fun. Home</u>		25a. REC'D BY REGISTRAR <u>NOV 25 1968</u>	
Address <u>Suitland Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16302

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16310

1. DECEASED NAME (Type or print) ERIC E. CALHOUN			First Middle Last			2a. DATE OF DEATH Month Day Year Nov 11 68			2b. HOUR 10:13 AM		
3. SEX M MALE			4. RACE N NEGRO			5. DATE OF BIRTH 10 Nov 68			6. AGE (In years last birthday) YRS. 17		
7a. BIRTHPLACE (State or foreign country) MD			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH PRINCE GEORGES Md.		
10. CITY OR TOWN OF DEATH ANDREWS AFB			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAFHOSP			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NA			12b. KIND OF BUSINESS OR INDUSTRY NA		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE WASH D.C.			13b. CITY OR TOWN WASH D.C.			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 3424 5th St SE Apt 11		
14. FATHER'S NAME First Middle Last THEODORE CALHOUN			15. MOTHER'S MAIDEN NAME First Middle Last VERA LOUISE RAYNOR			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. NA		
17. INFORMANT Father			Address same as item # 13			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) RESPIRATORY DISTRESS SYNDROME DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PREMATURE BIRTH DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10 Nov 1968 , to 11 Nov 1968 , that (I) (we) last saw the deceased alive on 11 Nov 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John A. Moore			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 11 Nov 68		
22d. PHYSICIAN'S NAME JOHN A. MOORE, CAPT, USAF, MC			22e. ADDRESS MALCOLM GROW USAFHOSP ANDREWS AFB								
23a. BURIAL, CREMATION, REMOVAL (Specify) Nov 14, 1968			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY MILLER CEMETERY			23d. LOCATION (City or Town) (County) (State) Jacksonville N.C.		
24. FUNERAL DIRECTOR JOHNSON & JENKINS F.A. Inc.			ADDRESS 4804 G.A. Ave NW WASH DC 20011			25a. RECEIVED BY REG. CLERK NOV 18 1968			25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

6000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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45M - 1-69

16302

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16310

1 DECEASED-NAME (Type or print)		First Vito	Middle	Last Candore	2a DATE OF DEATH Month November Day 3 Year 68		2b HOUR 10:30	
3 SEX Male		4 RACE Cauc.		5 DATE OF BIRTH 09-27-04		6 AGE (In years last birthday) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) Italy		7b. CIT. ZEN OF WHAT COUNTRY? U S A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges Md.		
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen. Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Tile Setter		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USCA. RES. DENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Prince Georges Seat Pleasant		13c. CITY OR TOWN Seat Pleasant		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 6902 A Street
14 FATHER'S NAME First Frank		Middle Candore		Last Angelina		15 MOTHER'S M. DEN NAME First Angelina Middle ? Last ?		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Oceola R. Candore		Address 6902 A St. Seat Pleasant		
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized peritonitis, with localized abscesses, DUE TO OR AS A CONSEQUENCE OF pelvic and left subdiaphragmatic. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Small bowel, cutaneous fistula. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5787								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from Sept. 28, 1968 to Nov. 3, 1968 , that (I) (we) last saw the deceased alive on Nov. 3, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.								
22b. SIGNATURE <i>Saul Schwartzbach</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED Nov. 3, 1968		
22d. PHYSICIAN'S NAME (Type) Saul Schwartzbach, M. D.		22e. ADDRESS 106 Irving St., Suite 405, Washington, D.C.						
23a B. URIAL, CREMATION REMOVAL (Specify) Burial		23b DATE 11-7-68		23c NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d LOCATION (City or Town) (County) (State) Clinton Pr. Geo. Md.		
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. S. E.		ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 6 1968		25b REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

1971

1971

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b. HOUR		
Francis A -			Caruso			Month 11 Day 8 Year 1968		12 ⁰⁰ P.M.		
3. SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 24 HRS		
Female		Cav		6-6-1893		75 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md.		
Italy		ITALY				Prince George				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Greenbelt			Greenbelt Convalescent Center			housewife				
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Prince George		Gaithersburg		YES		15612 Jones Lane	
14 FATHER'S NAME			15. MOTHER'S MA DEN NAME			Address				
First Middle Last			First Middle Last							
Joseph -			Demisa			GIACCIOTTI COPOL		WASHINGTON DC		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17. INFORMANT		Address			
No					MRS VINCENTINA J MAG		WASHINGTON DC			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Failure									12 hr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) Anteriorly located Coronary Artery Disease									15 yr.	
DUE TO, OR AS A CONSEQUENCE OF										
(c) Generalized Atherosclerosis									15 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION		Street or R.F.D. No.		City or Town		
22a. I certify that (1) (this hospital) attended the deceased from Feb. 1968 to Nov. 1968, that (1) (we) lost saw the deceased alive on 8 Nov. 1968, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
Wm A Wimsatt MD								8 Nov. 68		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
Wm A Wimsatt				3415 Hamilton St		Hyattsville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
Burial		Nov 11, 1968		Ft Lincoln Cemetery		Colmar Manor		Pro Geo Md.		
24 FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
F. Gasch's Sons				Hyattsville, Md.		DATE NOV 12 1968		J. Charles Judd		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

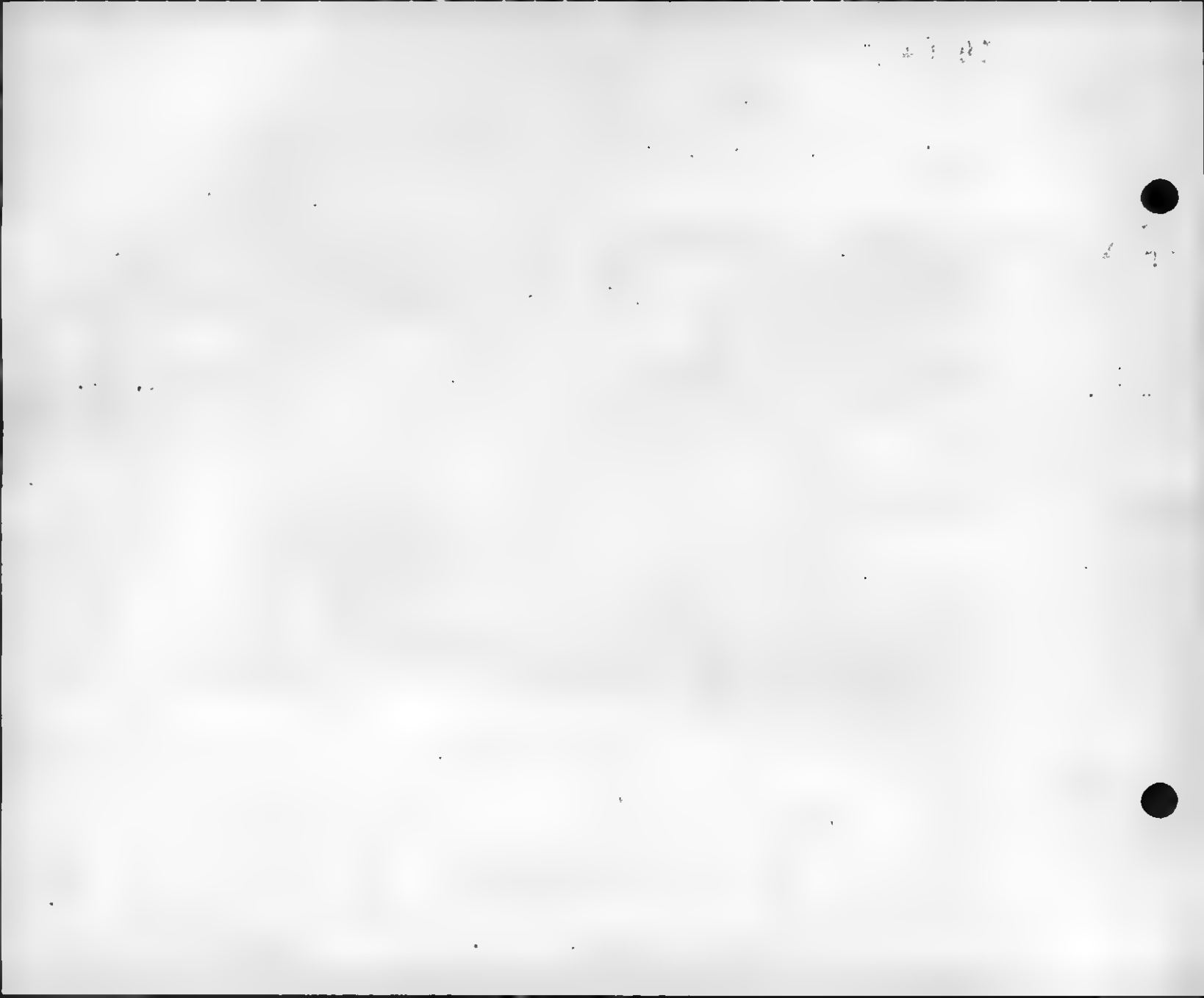
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or reinterment, and in any event within 72 hours after death.

16304

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16313

1 DECEASED NAME (Type or Print)		First Middle Last		2a DATE KNOWN OF DEATH		Month Day Year		2b HOUR	
Katharine Cobb Chappell				2c DATE PRONOUNCED DEAD		Month Day Year		2d HOUR	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		# UNDER 24 HRS			
female	white	Nov 26, 1892	76 YRS	MONTHS	DAYS	HOURS	MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Delaware		U S A				Prince George's		Md	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Beltsville		Eleven cedars Nursing home		Clerk		P O Dep't			
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md		Pro George's		Riverdale		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4717 Riverdale Road	
14. FATHER'S NAME		First Middle Last		15. MOTHER'S MAIDEN NAME		First Middle Last			
Winfield S Byron				Letitia Johnson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
no				Katharine Patrick		Riverdale, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u>								1 day	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								over 2 yrs	
(b) <u>1st stroke</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>CVA - 2 yrs before death</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)		JOHN L. KETHOE		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		11-26-68	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		Nov 29, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo		Md.	
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
F Gasch's Sons		Hyattsville, Md.		DEC 2 1968		Charles J. Jones			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. (The deceased remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>														
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR			
Estelle			Claggett						Nov. Month 20, Day 1968 Year		2:30PM			
3 SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
Female		Negro		Jan. 1, 1891				77 YRS.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Maryland			USA						Prince George's			Md		
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly				Prince Geo. Gen'l Hospital				Retired						
13a. USUAL RESIDENCE (Where deceased lived, if instit. an admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Maryland				Prince George's		Chapel Oaks				5702 Nome Street				
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last		
John W. Clark									Harriett Butler					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO				17. INFORMANT			Address			
								Sister			Mrs. Teresa Briscoe-5702 Nome Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>														
4500 DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause														
(b) <u>SUBARACHNOID HAEMORRHAGE</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(c) <u>HYPERTENSION.</u>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that xx (this hospital) attended the deceased from <u>Nov. 14, 1968</u> , to <u>Nov. 20, 1968</u> , that xx (we) last saw the deceased alive on <u>Nov. 20, 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. xx (we) (did) (do not) view the body after death.														
22b. SIGNATURE <u>P. C. Xavier, M. D.</u>								DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS		Nov. 21, 1968		
P. C. Xavier, M. D.										Prince Geo. Gen'l Hospital, Cheverly, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			11/23/68		Mt. Olivet Cemetery			Washington, D.C.						
24. FUNERAL DIRECTOR								25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Stewart Funeral Home-4001 Benning Road, N.E.								DATE		NOV 2 1968				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 45M 11/27/68

16306

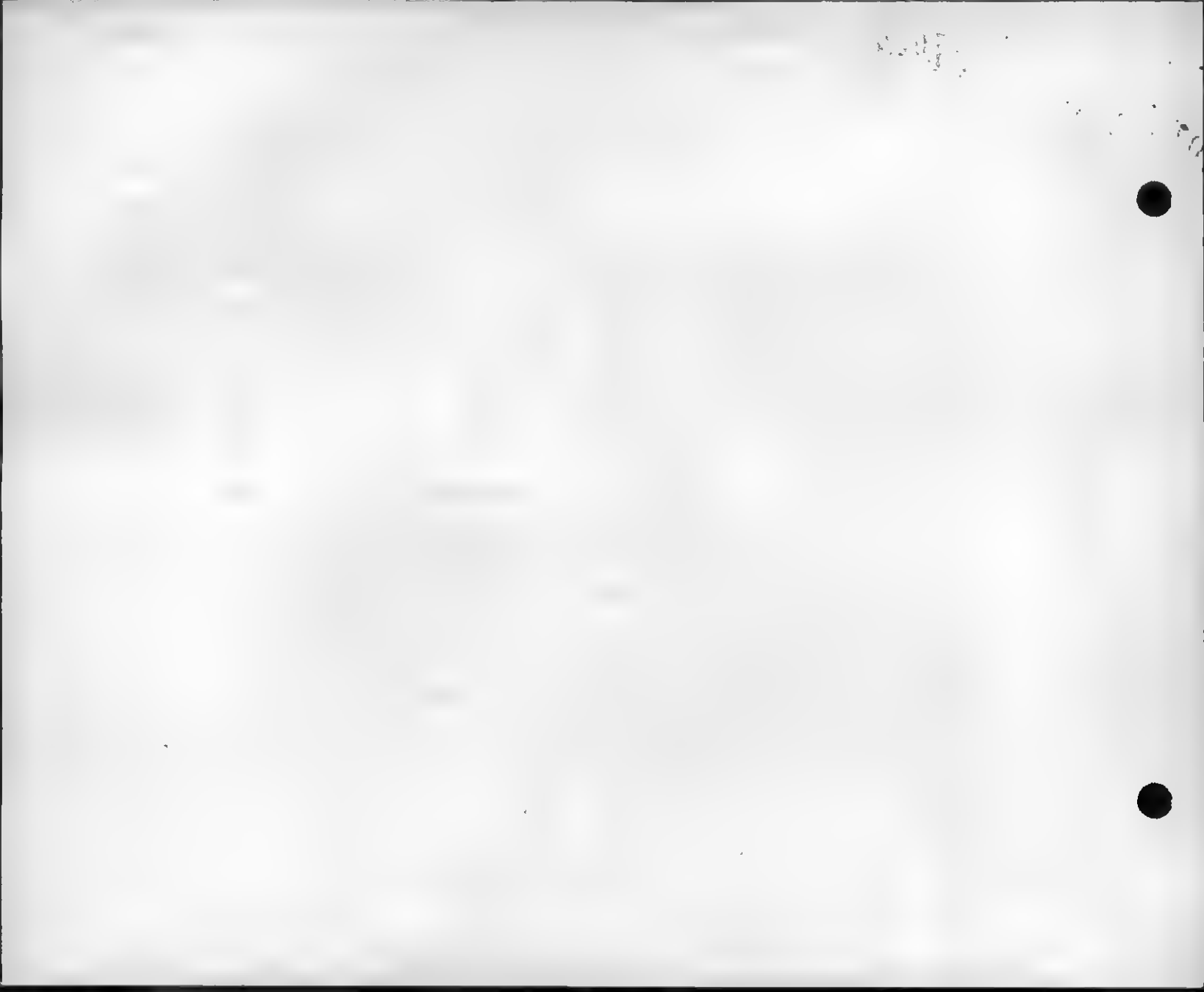
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16320

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Edna Pearl Clements			First Middle Last		2a. DATE OF DEATH Month Nov. Day 27 Year 1968			2b. HOUR 7:05 P M	
3. SEX F.		4. RACE White		5. DATE OF BIRTH 11-12-91		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges General			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MD			13b. COUNTY P. J. A. Edgewater			13c. CITY OR TOWN Keymar Dr.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME William Meinburg			First Middle Last			15. MOTHER'S MAIDEN NAME UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO. NO			17. INFORMANT Louis W LITZ Address 9100 Armstrong Rd. Upper Marlboro Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma 1538 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic carcinoma of the liver DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma of colon CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) L. ASHD									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/5 , 19 68 , to 11/27 , 19 68 , that (I) (we) last saw the deceased alive on 11/27 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DR. DAVID ANDERS					MD DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 11-27-68		
22d. PHYSICIAN'S NAME (Type) DR. DAVID ANDERS					22e. ADDRESS 3308 Dodge Park Rd Sandover Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Nov 30, 1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Seatons Md.			
24. FUNERAL DIRECTOR Robert E. W. [illegible]					ADDRESS 4308 Seatons Rd Seatons Md		25. RECD BY REGISTRAR DATE DEC 3 1968		25b. REGISTRAR'S SIGNATURE [illegible]

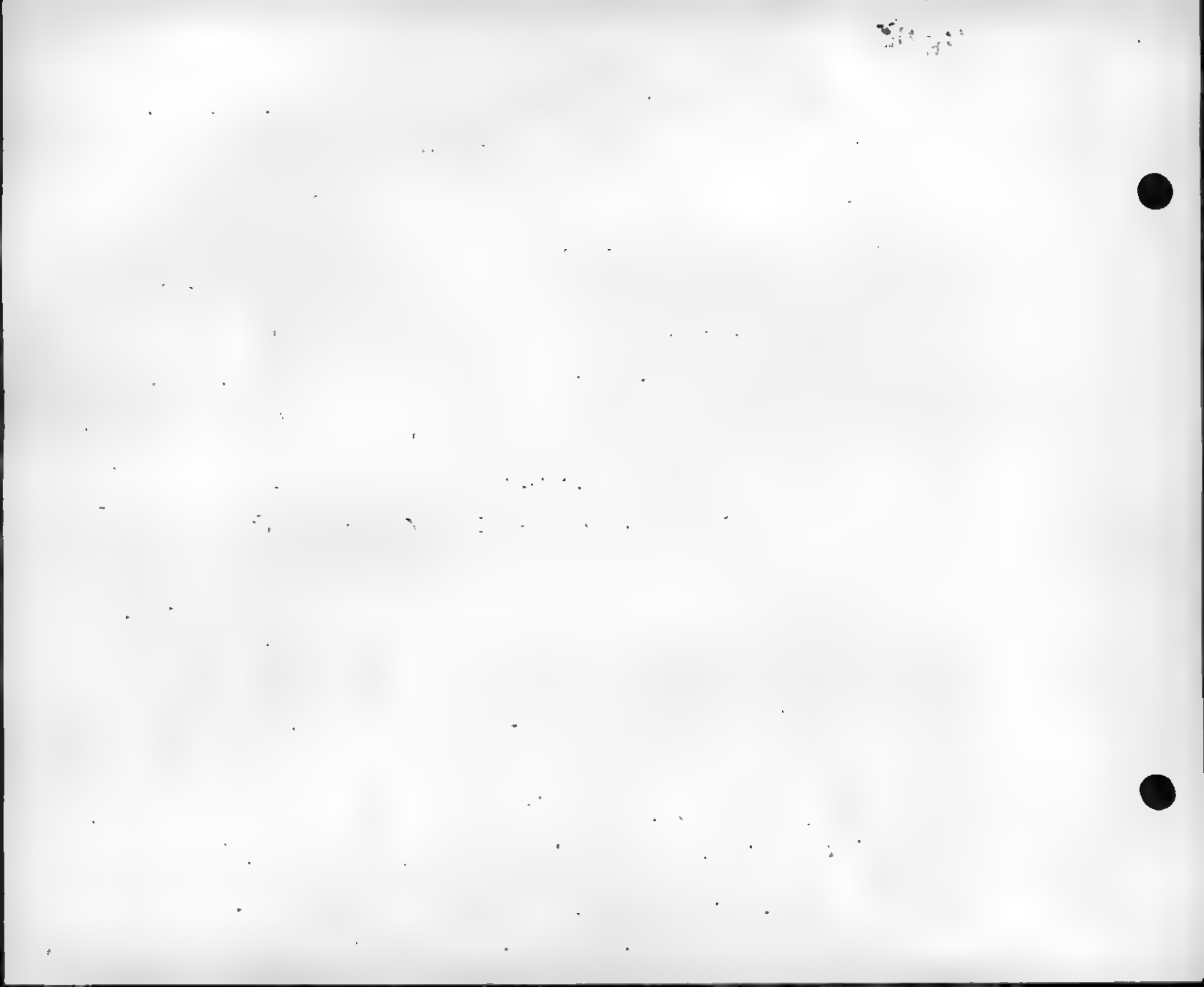
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16307		CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH			2b HOUR
William Heman Clements Sr								Month Day Year Nov 3, 1968			12:40 PM
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (in years last birthday)		7 JANUARY 1 YEAR		IF UNDER 24 HRS
male		white		July 20, 1907			61 YRS		MONTHS DAYS		HOURS MIN
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY		
Washington D C		USA					Prince George's Md			Physician	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Hyattsville		6001 35th ave			General Practice						
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before adm-ssion) STATE		13b. COUNTY		13c. CITY OR TOWN		3d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Md		Pro Geo		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6001 35th ave			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Lyman J Clements				Harrlette C Battles							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT				Address			
Yes, no, or (unknown)		220 44 2705		W H Clements Jr				Cheverly, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURED ANEURYSM OF LEFT VENTRICLE										FEW MIN	
4109 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION										28 DAYS	
DUE TO, OR AS A CONSEQUENCE OF (c) THROMBOSIS OF LEFT CORONARY ARTERY										28 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from OCT 27, 1968, to NOV 3, 1968, that (I) (we) last saw the deceased alive on NOV 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		J. E. BOWMAN, M.D.				22c. DATE SIGNED		NOV. 3, 1968			
22d. PHYSICIAN'S NAME (Type)		J. E. BOWMAN, M.D.				22e. ADDRESS		4021-18TH ST., N.E.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Nov 7, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
F. Gasch's Sons Hyattsville, Md.				DATE NOV 8 1968				J. Charles Judge			



FOR STATE HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1-2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 1515
10M REV 1-68

16308

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16329

1 DECEASED-NAME (Type or Print) William Ray Clements			2a DATE KNOWN OF DEATH MATED 11-30-68 19 2:32pm			2b HOUR		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 7-5-1944	6 AGE (In years last birthday) 24 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	IF UNDER 24 HRS HOURS 0 MIN.	2c DATE PRONOUNCED DEAD Month 11 Day 30 Year 1968 19 2:44pm M.		
7a BIRTHPLACE (State or foreign country) Washington, D. C.		7b CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md.		
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Policeman		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b COUNTY Prince George's			13c CITY OR TOWN Hyattsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME William Clements			15 MOTHER'S MAIDEN NAME Irene Phillips			16 ADDRESS 2716 73rd. Place		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b SOCIAL SECURITY NO unknown			17 INFORMANT Blanche R. Clements ADDRESS 2718 - 74th Ave.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple gunshot wounds of head and chest 765X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 981X								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year 2:30pm 11-30-1968			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Shot by assailant.		
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 7000 block Greig Street, Seat Pleasant, Prince George Co., Md.			21f LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD			22b DATE SIGNED 12-1-68			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12-4-68			23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		
24 FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. S. E.			25a. REC'D BY REGISTRAR DEC 9 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16309

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16323

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR am	
Frank		Anthony		Coaplin				11		22		1968		2:00			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		Day		Year	
M	W	13 Mar. 1907		65 1/4 YRS		MONTHS		DAYS		11		22		1968		5:09 a.m.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9. COUNTY OF DEATH									
VIRGINIA		USA		WIDOWED		DIVORCED		Prince George									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly				Prince George Hosp.				ANIMAL HELPER				AGRICULTURE					
13a. USUAL RESIDENCE (Where deceased admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?					
Md.				Ann Arundel				Laurel				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				13e. STREET AND NUMBER									
NATHAN COAPLIN				ELIZABETH BOYLE				3410 Suderville So.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT				ADDRESS					
				579-22-1487				HELEN COAPLIN				ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Unknown APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min.																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 420																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f. LOCATION Street or RFD No				City or Town					
												County					
												State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASS STANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type)				John Kehoe, M.D., Riverdale				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				11-23-68					
				ADDRESS (Street, city, town, or county)													
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY, OR CREMATORY				23d. LOCATION (City or town)					
Burial				11-25-68				Ft Lincoln				Colman Manor Trnd					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Banachian Funeral Home Laurel								NOV 26 1968				Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16310

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16320

1 DECEASED NAME (Type or print) JESSIE		First LEE		Middle COLLINS		Last		2a. DATE OF DEATH Month 11 Day 29 Year 1968		2b. HOUR 8:05 PM	
3 SEX female		4 RACE Caucasian		5. DATE OF BIRTH 9-16-1882		6. AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.					
10 CITY OR TOWN OF DEATH Hyattsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Manor Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) Navy Dept.		12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't.					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b COUNTY Washington		13c CITY OR TOWN Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 4124 Fessenden St. N.W.			
14 FATHER'S NAME First William		Middle H.		Last Hunter		15 MOTHER'S MAIDEN NAME First Catherine		Middle Caldwell		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes		(If yes give war or dates of service) WW I		16b SOCIAL SECURITY NO. 577-12-1079-D		17 INFORMANT Wash. Address D.C., 20016 Mrs. Paul R. Wilson, Neice, 5607 Marengo Rd.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4221 Generalized Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years 4 years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Osteoarthritis - Spine and hips											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Nov. 9 , 19 64 , to Nov. 29 , 19 68 , that (I) (we) last saw the deceased alive on Nov. 27 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Francis P. Hannan		22c PHYSICIAN'S NAME (Type) FRANCIS P. HANNAN		22d ADDRESS 1511-17 ST. N.W. WASH. D.C.		22e MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f DATE SIGNED Nov. 29, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 12-4-1968		23c NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d LOCATION (City or Town) Arlington, Virginia		County		State	
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.,		ADDRESS 5150 Wisc. Ave. N.W., Wash., D.C., 20016		25a REC'D BY REGISTRAR DEC 5 1968		25b REGISTRAR'S SIGNATURE Charles J. Jones					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

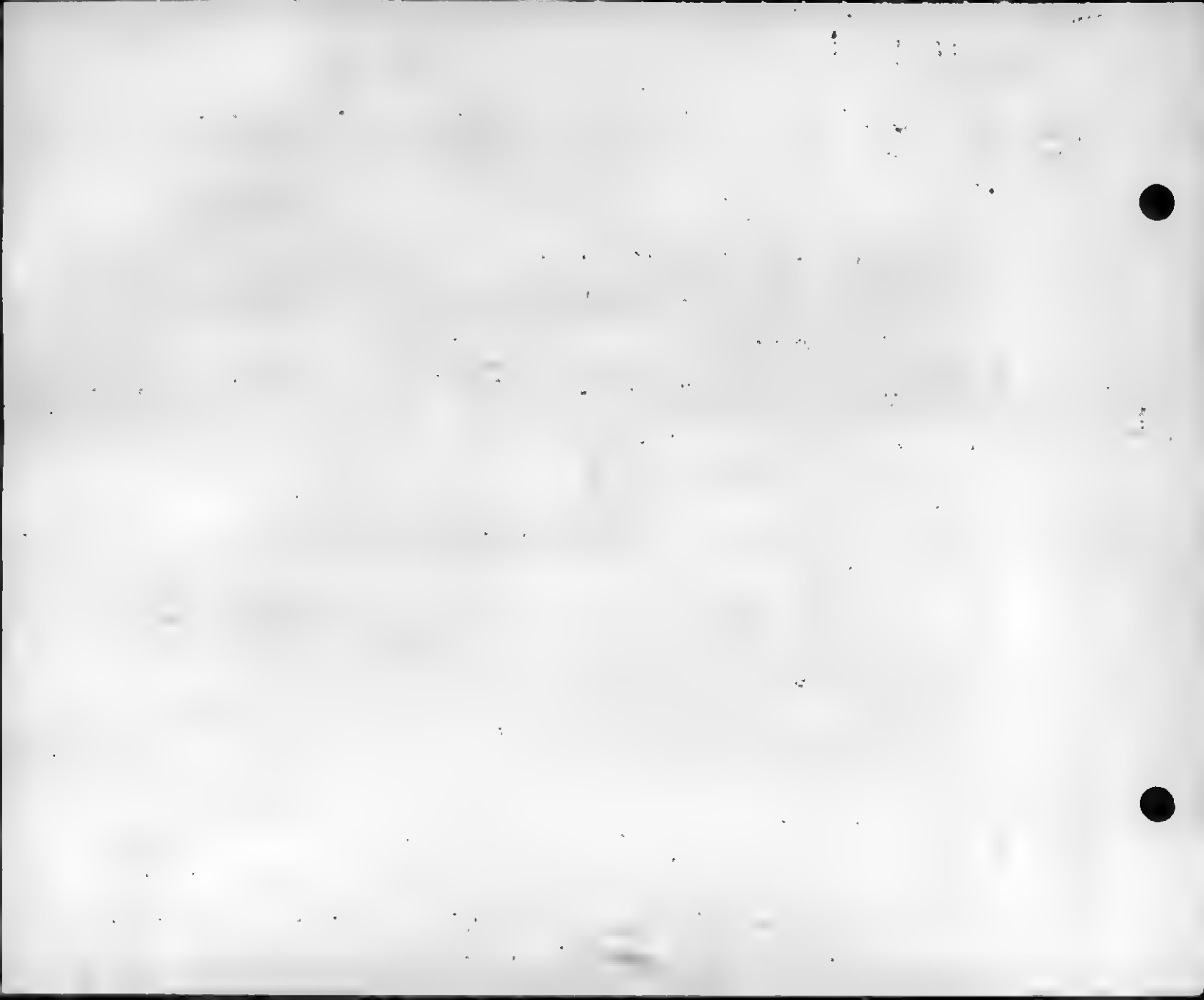
VR A15 (4)
30M REV. 1/68

163112

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16325

1 DECEASED NAME (Type or print) <i>WILLIAM G. COLLINS</i>			2a DATE OF DEATH Month <i>Nov</i> Day <i>13</i> Year <i>1968</i>			2b HOUR <i>6 A</i> M							
3 SEX <i>male</i>		4 RACE <i>white</i>		5. DATE OF BIRTH <i>Sept 14, 1881</i>			6 AGE (in years last birthday) <i>87</i> YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <i>md</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U S A</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Prince George's</i> Md				
10 CITY OR TOWN OF DEATH <i>Beltville, Md.</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>4916 Harford ave</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Builder</i>				12b KIND OF BUSINESS OR INDUSTRY <i>Self employed</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>				13b. COUNTY <i>Pro George's</i>				13c. CITY OR TOWN <i>Beltville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>4916 Harford ave</i>	
14 FATHER'S NAME First Middle Last <i>Thomas P Collins</i>						15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Linton</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO <i>212 20 1342A</i>				17. INFORMANT Address <i>Rosetta G Collins Beltville, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cachexia</i> <i>185X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Seul Carcinomatosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma Prostate</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i> <i>12 yrs.</i> <i>15 yrs.</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>177X</i>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2. Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 19 38</i> to <i>11/12 1968</i> , that (I) (we) last saw the deceased alive on <i>11/10 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>J M Warren Md</i> DEGREE ATTENDING <input checked="" type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/> 22d. PHYSICIAN'S NAME (Type) <i>J M WARREN</i> 22e. ADDRESS <i>Laurel Md</i>								22c. DATE SIGNED <i>11/13/68</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>Nov 16, 1968</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>Colmar Manor Pro Georges Md</i>	
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>				ADDRESS <i>Hyattsville, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>NOV 18 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1 DECEASED NAME (Type or Print)			First Kinston			Middle Cooper			Last Cooper			2a DATE KNOWN OF DEATH EST. MATED <input checked="" type="checkbox"/> 11-1-68		2b HOUR 17:23am M	
3 SEX Male		4 RACE Negro		5 DATE OF BIRTH 1-21-1937		6 AGE (In years last birthday) 31 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year 11 1 68 19 8:06am M		2d HOUR	
7a BIRTHPLACE (State or foreign country) North Carolina				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH Prince George's Md.			
10 CITY OR TOWN OF DEATH Cheverly				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)				12b KIND OF BUSINESS OR INDUSTRY			
13a USLA RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE District of Columbia				13b CITY OR TOWN Washington				13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13d STREET AND NUMBER 142 Joliet St. N.E.			
14 FATHER'S NAME First Middle Last Not stated				15 MOTHER'S MAIDEN NAME First Middle Last Not stated											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO (If yes give war or dates of service) None				17 INFORMANT Pearline Cooper-142 Joliet Street, SW. #B				ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO, OR AS A CONSEQUENCE OF Evisceration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 2161															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year 7:20am 11-1-1968				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Driver of cement truck involved in collision.							
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) Rt. 495, south of Rt. 4, Prince George County, Maryland				21f LOCATION Street or RFD No City or Town County State							
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED 11-1-68							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b DATE 11-5-68				23c NAME OF CEMETERY OR CREMATORY Church Cemetery				23d LOCATION (City or Town) (County) (State) Rocky Mount, North Carolina			
24 FUNERAL DIRECTOR John T. Rhines Company Funeral Home 3015 12th Street, N. E.				25a REC'D BY REGISTRAR NOV 6 1968				25b REGISTRAR'S SIGNATURE Charles Judge							

00001.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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<div style="text-align: right;">16327</div> <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Richard Francis Coulter Sr						DATE ESTIMATED 11-8-68			9 am M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR	7 UNDER 24 HRS	2c DATE PRONOUNCED DEAD			2d HOUR		
Male	White	29 June 1905	63 YRS	MONTHS	DAYS	11 9 68 19 8:00 pm M					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Pennsylvania		U S A				Prince George's Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Maintenance engineer			Hospital		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Maryland			Prince George's			Bladensburg			YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e STREET AND NUMBER					
Thomas Coulter			?			5506 Newton Street # 3.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
no			170 05 8697			Richard F Coulter Jr			Adelphi, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Infarction of brain											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Occlusion of cerebral artery										4 days	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
CAUSE OF DEATH				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or RFD No. City or Town County State			
AT WORK											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			11-11-68		
John Kehoe MD Riverdale, Md.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL, (Specify)						23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial						Nov 13, 1968			George Washington cemetery Hyattsville Pro Geo Md.		
24. FUNERAL DIRECTOR						ADDRESS			25a. RECD BY REGISTRAR		
F. Gasch's Sons						Hyattsville, Md.			25b. REGISTRAR'S SIGNATURE		
						NOV 18 1968			Charles Judge		

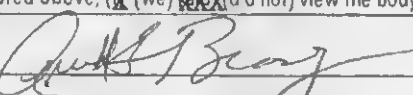



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 6 Film 406 11/13/68 vk
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16325

1. DECEASED-NAME (Type or print) Anastasia		First G	Middle Coward	Last November	2a. DATE OF DEATH Month 3 Day 68 Year 8:30A	2b. HOUR
3 SEX Female	4. RACE Cauc.	5. DATE OF BIRTH NOV 7 1922		6 AGE (In years last birthday) 45 46 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) WASH. D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges		Md
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Prince Georges	13c. CITY OR TOWN Riverdale	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4701 Ravenswood Road	
14 FATHER'S NAME First CHARLES J. Middle SMITH Last UNKNOWN		15 MOTHER'S MAIDEN NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (a, or unknown) <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO 577 46 5256		17 INFORMANT HUBERT WRIGHT		Address 512 2ND ST N.Y. N.Y.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post Necrotic Cirrhosis of Liver 5718 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Viral Hepatitis DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) EXIC						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (X) (this hospital) attended the deceased from October 30, 1968 , to November 3, 1968 , that (X) (we) last saw the deceased alive on Nov. 3, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.						
22b. SIGNATURE 		DEGREE Arnold G. Brody, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3 Nov 68
22d. PHYSICIAN'S NAME (Type) Arnold G. Brody, M.D.		22e. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11-6-68		23c. NAME OF CEMETERY OR CREMATORY WASH. NAT. CEM		23d. LOCATION (City or Town) (County) (State) SUITLAND MD.
24. FUNERAL DIRECTOR W W CHAMBERS CO		ADDRESS 1400 CHARIN ST. N.W. WASH. D.C.		25a. REC'D BY REGISTRAR NOV 8 1968		25b. REGISTRAR'S SIGNATURE 



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
304 REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH	
Redman		Haywood		Crouch		Nov. 13 1968		25 HOUR 1:45 PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7 UNDER 1 YEAR MONTHS DAYS	
male		white		Aug 26, 1914		54 YRS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		U S A				Prince George's Md			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Hyattsville		6214 43rd ave		Laboratory machinist		U S Gov't			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md		Pro George's		Hyattsville				6214 43rd Ave	
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME	
Arthur Crouch								Elizabeth Brooks	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
no		577 10 9454		Mary M Crouch		Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cachexia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Generalized carcinoma metastasis</u>								1 1/2 yrs	
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Carcinoma of colon</u>								about 1 1/2 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from <u>June 22, 1967</u> to <u>Nov 13, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. ADDRESS					
David S Clayman M.D.		Nov 13, 1968		6311 Baltimore ave., Riverdale, Md.					
22d. PHYSICIAN'S NAME (Type)		22b. DATE		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City or Town)		(County) (State)	
David S Clayman		Nov 16, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo		Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		Nov 16, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo		Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
F. Gasch's Sons		Hyattsville, Md.		NOV 18 1968		Charles J. [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

304 REV. (4) 1/68

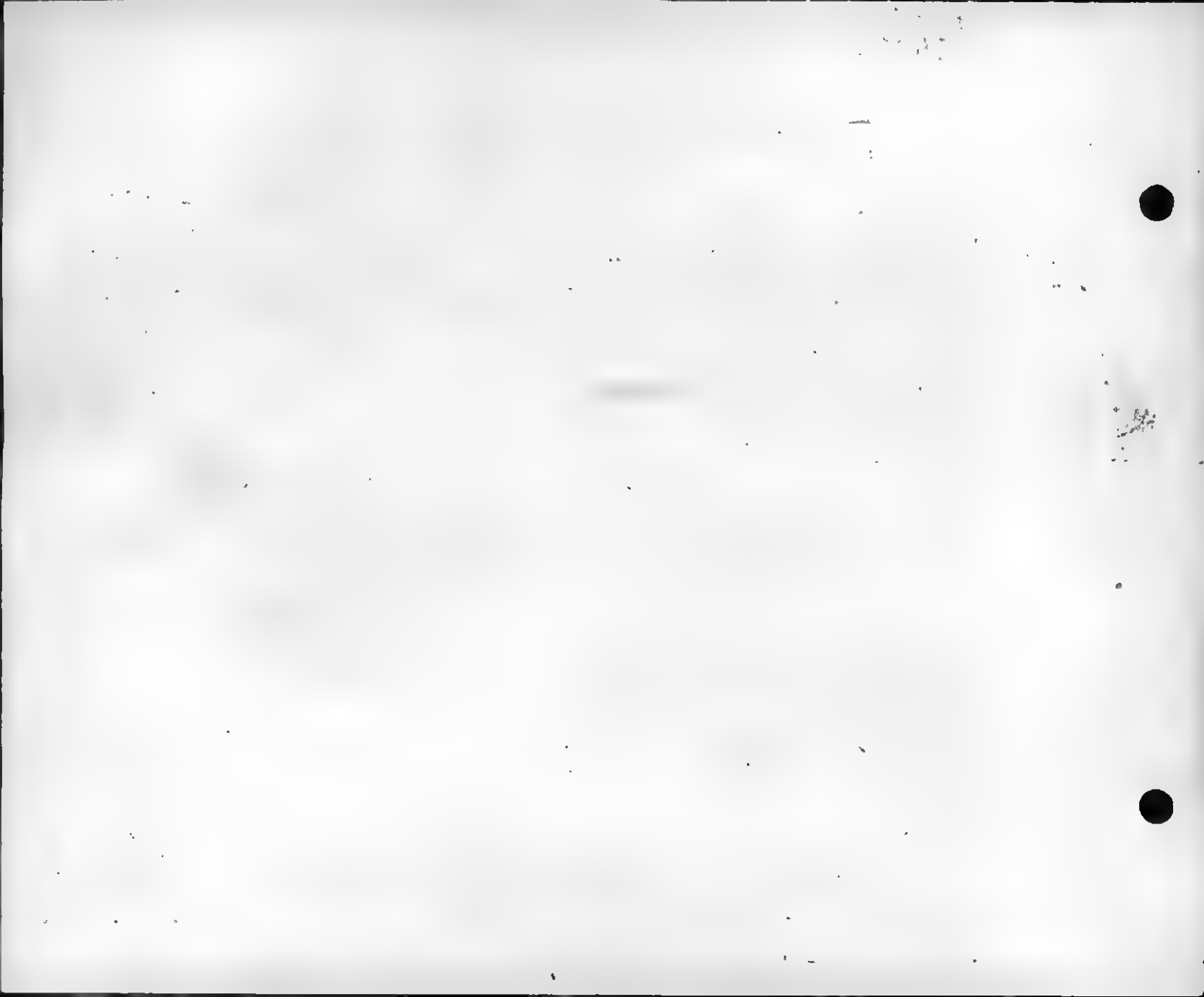
16316

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16316

1. DECEASED-NAME (Type or print) CURTIN		First LAST Middle		Last FIRST		2a. DATE OF DEATH Month Nov. Day 17 Year 1968		2b. HOUR 9:00 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JAN. 16, 1888		6. AGE (in years last birthday) 80 YRS.		IF UNDER YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE		Md.	
10. CITY OR TOWN OF DEATH BERKSHIRE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7402 Hansford St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Plumber		12b. KIND OF BUSINESS OR INDUSTRY Plumbing			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Ma.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Berkshire		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7402 Hansford St.	
14. FATHER'S NAME First Middle Last OLIVER CURTIN		15. MOTHER'S MAIDEN NAME First Middle Last JOSEPHINE THOMAS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 579-01-4650-4		17. INFORMANT Julia Schaub		Address 7402 Hansford St. Berkshire			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MASSIVE CEREBRAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROTIC C.V. DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 3 yrs.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hours							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Nov. 16, 1968 to Nov. 17, 1968 , that (I) (we) last saw the deceased alive on Nov. 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Benjamin S. Pecson		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11-17-68			
22d. PHYSICIAN'S NAME (Type) BENJAMIN S. PECSON		22e. ADDRESS 6106 OLD SILVER HILL ROAD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-20-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Pr. Geo. Md.			
24. FUNERAL DIRECTOR Wilhelm Funeral Home		ADDRESS 4303 Suitland Rd. Suitland, Md.		25a. REC'D BY REGISTRAR NOV 21 1968		25b. REGISTRAR'S SIGNATURE James J. Jones			

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

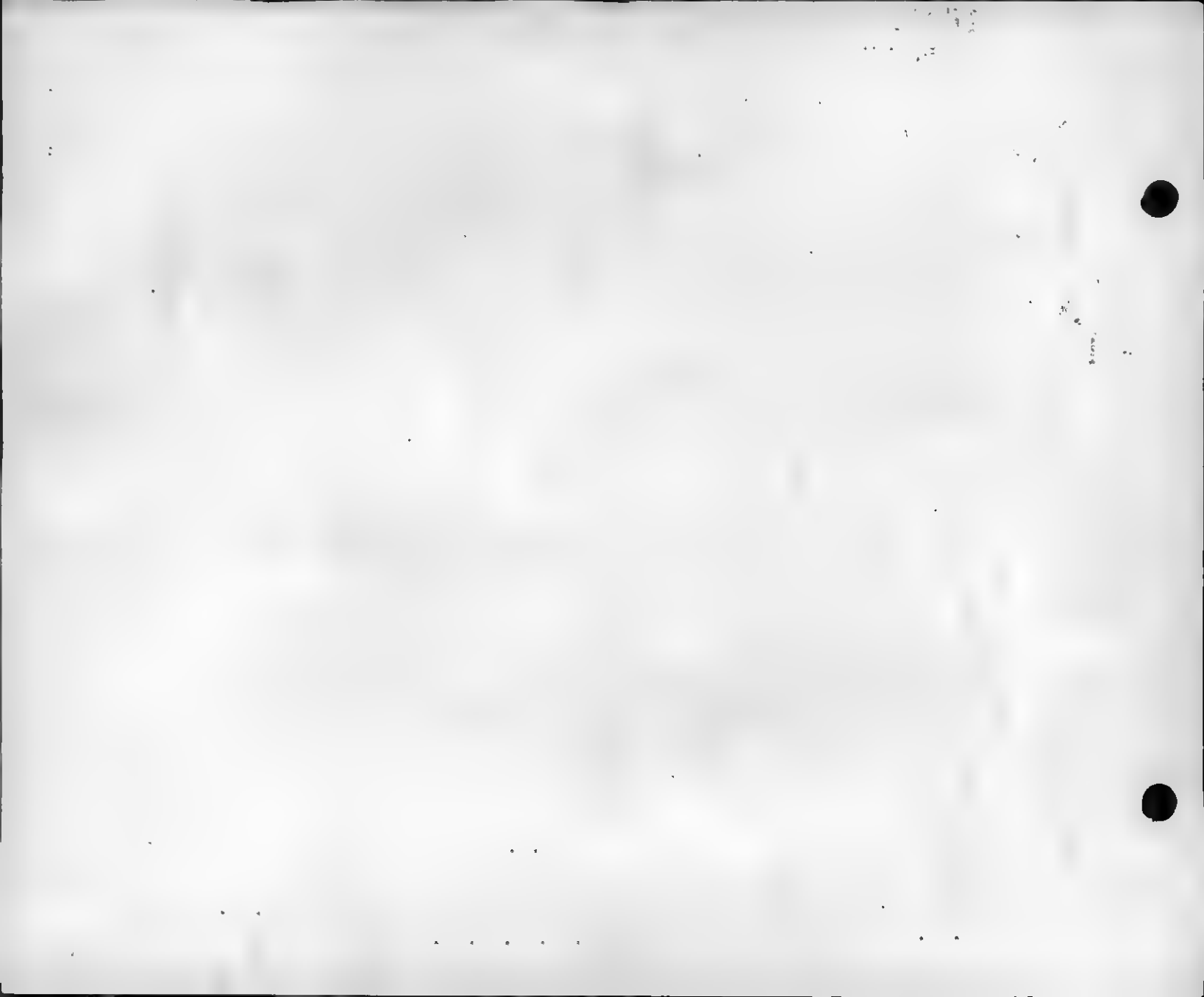
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16317 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 18 Film 409 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b HOUR am		
Nathaniel						Daniels		11		27	68	1:00			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD		Month	Day	Year	2d HOUR am
M	Negro	29 May -42		26 YRS						11		27	68	8:00	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH								Md	
North Carolina		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY									
Cheverly		Prince George Hosp													
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER							
Md		Prince George		Hyattsville		NO <input type="checkbox"/>		Burlington Rd.							
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last	
Joseph						Daniels		Noami						Grissom	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:												Minutes			
IMMEDIATE CAUSE (a) Heart failure															
DUE TO, OR AS A CONSEQUENCE OF															
(b) A S H D															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
4200															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State					
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b DATE SIGNED											
John Kehoe		John Kehoe, M.D., Riverdale		11-28-68											
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)					
removal		11-30-68				Durham, N. C.									
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE									
R. N. Horton Inc		1324 You, St. N. W. D. C.		DEC 2 1968		Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-15 (4)
30M REV 1/68

16318

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1633

1 DECEASED NAME (Type or print) First Middle Last Carey T. David Sr.			2a. DATE OF DEATH Month Day Year 11 12 68			2b. HOUR M 11							
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH July 8, 1897		6. AGE (In years last birthday) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS 71		IF UNDER 24 HRS HOURS MIN 71			
7a. BIRTHPLACE (State or foreign country) DC		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md							
10. CITY OR TOWN OF DEATH College Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Post Office			12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't				
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN College Park			13d. INSURE CITY LIMITS? YES NO <input type="checkbox"/>			13e. STREET AND NUMBER 8417 Patuxent Avenue	
14 FATHER'S NAME First Middle Last Wm R. David				15. MOTHER'S MAIDEN NAME First Middle Last ? Parker									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes (If yes give war or dates of service) WW I				16b. SOCIAL SECURITY NO. 216 44 9452		17. INFORMANT Margaret W David Address College Park, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe stenosing coronary arteriosclerosis with DUE TO, OR AS A CONSEQUENCE OF complete occlusion of right branch. Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last: 4-0-1 (b) Severe arteriosclerotic heart disease with extensive DUE TO, OR AS A CONSEQUENCE OF myocardial fibrosis. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) (severe) Pulmonary edema (severe); old cerebral infarction; generalized arteriosclerosis.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) this hospital attended the deceased from 10-8-63 , 19 63 , to 11-12 , 19 68 , that (I) was last saw the deceased alive on 11-1 , 19 68 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.													
22b. SIGNATURE <i>William B. Gunther</i>						DEGREE MD			22c. DATE SIGNED 11-13-68				
22d. PHYSICIAN'S NAME (Type) William B. Gunther, M. D.						22e. ADDRESS 4917 Edgewood Road, College Park, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Nov 16, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR F. Gasch's Sons Address Hyattsville, Md.						25a. REC'D BY REGISTRAR NOV 18 1968			25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>				

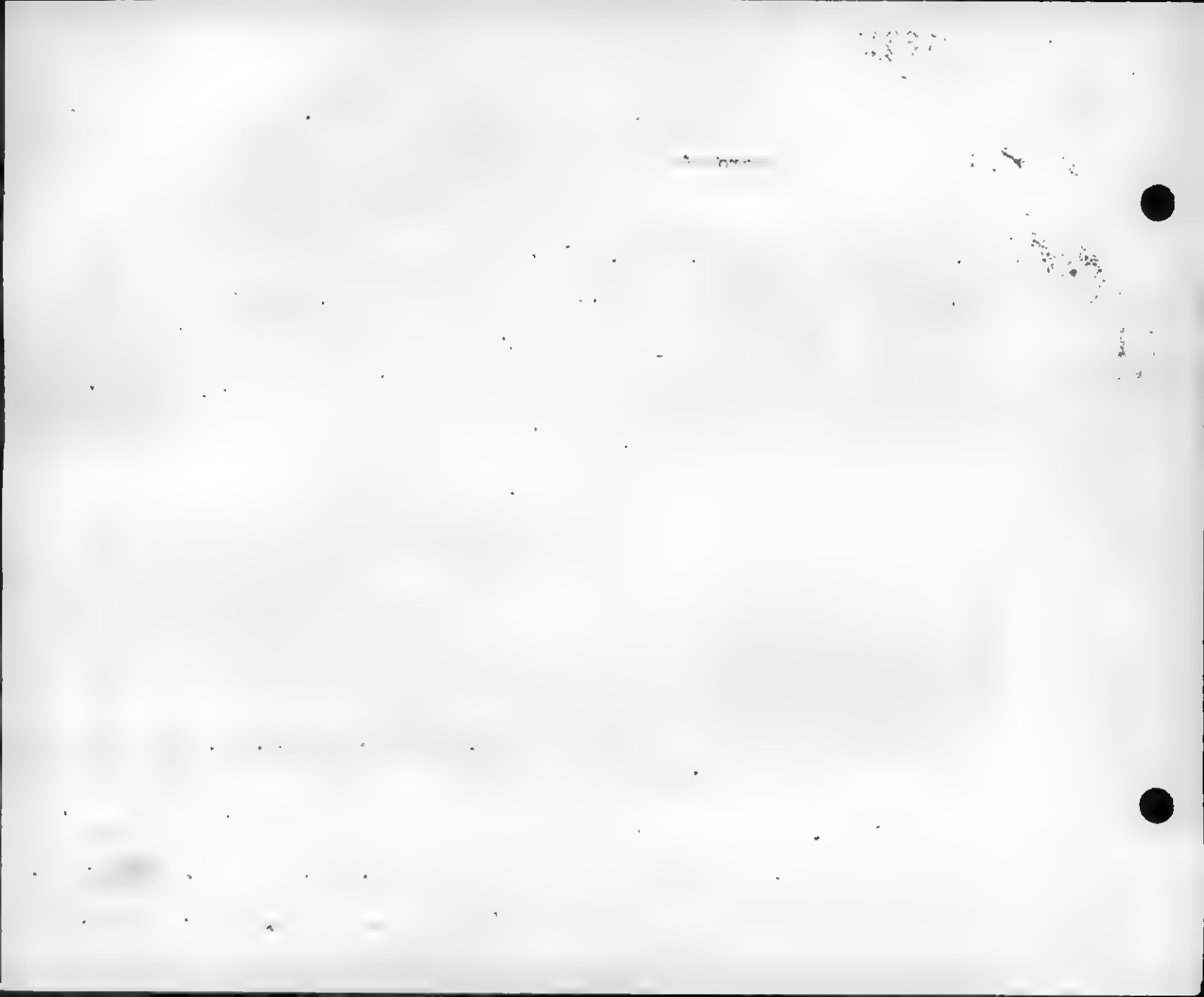
MEDICAL CERTIFICATION

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 16318 16330 </div> <div style="display: flex; justify-content: space-between;"> Item # 23a; File # 3407 12/3/68 km CERTIFICATE OF DEATH </div>									
1. DECEASED-NAME (Type or print) First Middle Last Mary D. Davis					2a. DATE OF DEATH Month Day Year Nov. 11, 1968			2b. HOUR 2:24 P M	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 8/30/68		6. AGE (In years lost birthday) YRS. 2 MONTHS 2 DAYS 2 HOURS 2 MIN			
7a. BIRTHPLACE (State or foreign country) P. Geo. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? Prince Geo. Gen'l Hospital		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md			
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Geo. Gen'l Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER Box 3572			14. FATHER'S NAME First Middle Last Thomas Davis			15. MOTHER'S MAIDEN NAME First Middle Last Mary Louise Pinkney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address Thomas Davis - See above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bacterial Meningitis 3201 DUE TO, OR AS A CONSEQUENCE OF (b) Pneumococcal Infection DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 40									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (he) (this hospital) attended the deceased from Nov. 10, 1968 to Nov. 11, 1968 , that (he) (we) last saw the deceased alive on Nov. 11, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death									
22b. SIGNATURE Edwin Jensen, M.D. DEGREE MD ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED Nov. 12, 1968			
22d. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M. D.						22e. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11/14/68		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery, Waldorf, Charles, Md.		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR Maitell Adams Aguasson		ADDRESS		25a. REC'D BY REGISTRAR NOV 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

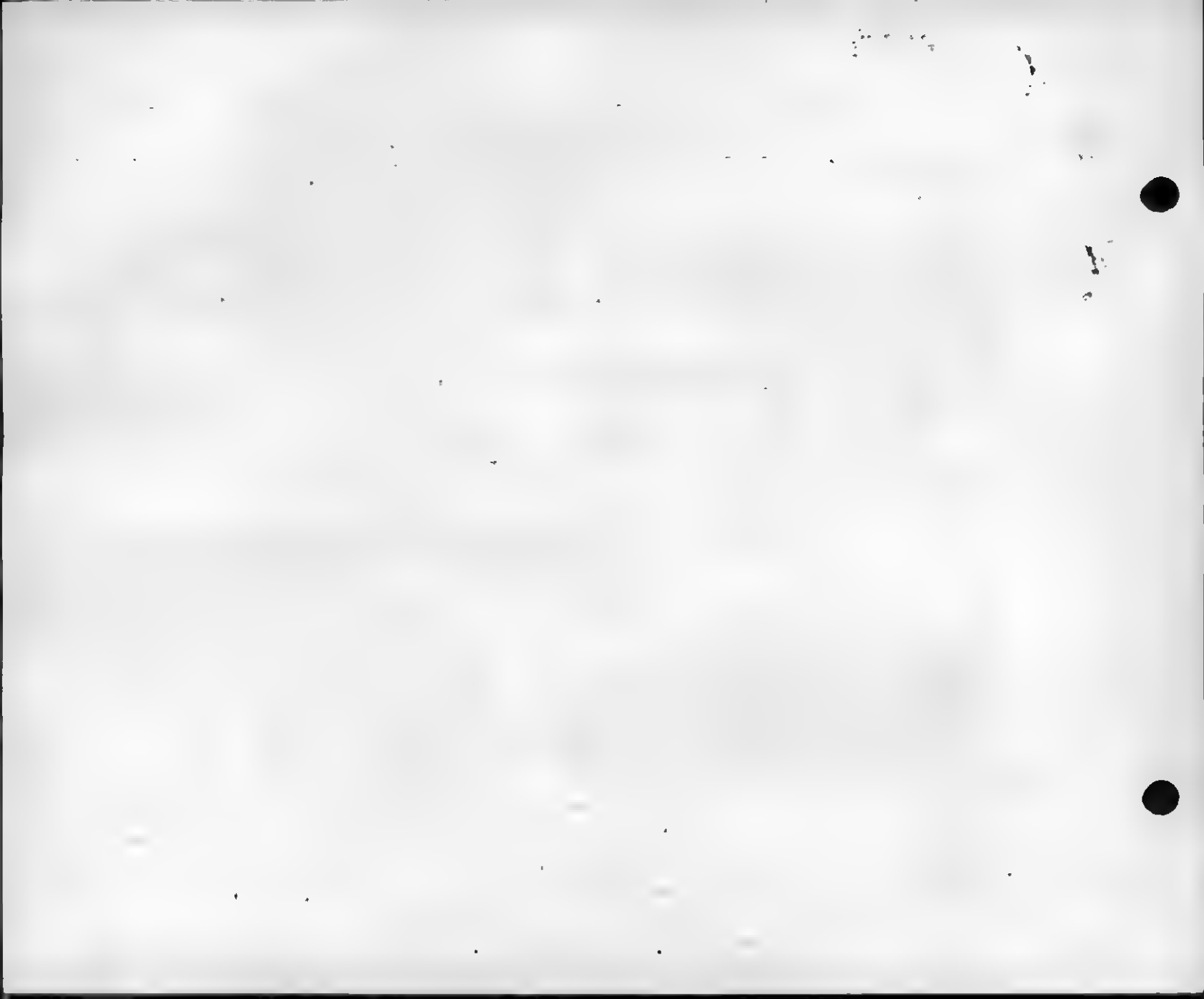
16320

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16330

1 DECEASED NAME (Type or Print) Michael John Demma			2a DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> 11-29-68 1912:30pm			2b HOUR		
3 SEX Male	4 RACE White	5. DATE OF BIRTH 2-21-1909	6 AGE (In years last birthday) 59 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD Month 11 Day 29 Year 68	2d HOUR 5:42pm		
7a BIRTHPLACE (State or foreign country) D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md		
10 CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Sales		12b KIND OF BUSINESS OR INDUSTRY Self Emp
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before address on) - STATE Maryland			13b COUNTY Prince George's Mt. Rainier			13c CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3208 35th. Street
14 FATHER'S NAME Frank Demma			15 MOTHER'S MAIDEN NAME Lucy ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES			16b SOCIAL SECURITY NO. 578148902			17. INFORMANT Mary C. Demma (wife) Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Intra cerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF <u>Hypertensive vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b DATE SIGNED 11-30-68		
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE 12-3-68		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d LOCATION (City or Town) (County) (State) Washington, D.C.		
24. FUNERAL DIRECTOR Nalley Funeral Home, Mt. Rainier, Md.				ADDRESS		25a REC'D BY REGISTRAR DEC 5 1968		25b REGISTRAR'S SIGNATURE H. Charles Judge



16321

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16330

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) WAGNER		First WAGNER		Middle DICK		Last DICK		2a DATE OF DEATH Nov Month 25 Day 1968 Year		2b HOUR 2:40 AM	
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH 17 FEB 1920		6 AGE (In years last birthday) 48 YRS		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) LA.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH PRINCE GEORGE'S Md					
10 CITY OR TOWN OF DEATH ANDREWS AFB		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM CROW USAFHOSP		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PILOT		12b KIND OF BUSINESS OR INDUSTRY USAF					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE VIRGINIA		13b COUNTY SANFORD		13c CITY OR TOWN ANNADALE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3602 DRUID LANE			
14. FATHER'S NAME First MATTHEW Middle W. Last DICK		15. MOTHER'S MAIDEN NAME First JESSE Middle P. Last EASLEY									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> (If yes give war or dates of service) YES 1941-1968		16b. SOCIAL SECURITY NO. 439-035-672		17. INFORMANT Address WIFE SAME AS ITEM # 13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY ARREST 150X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) WIDE SPREAD CARCINOMA OF THE ESOPHAGUS DUE TO, OR AS A CONSEQUENCE OF (c) 3 Months										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 150X											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that XX (this hospital) attended the deceased from <u>August</u> , 19 <u>68</u> , to <u>25 Nov</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>25 Nov</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED 25 Nov 68							
22d. PHYSICIAN'S NAME DR. ABRAHAM, CAPT, USAF, MC		22e ADDRESS MALCOLM CROW USAF HOSP ANDREWS AFB MD									
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 11-30-68		23c NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d LOCATION (City or Town) (County) (State) New Orleans La.					
24. FUNERAL DIRECTOR W. W. Chambers Co. 517-11th St. S.E. D.C.		ADDRESS		25 REC'D BY REGISTRAR DATE DEC 2 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16322

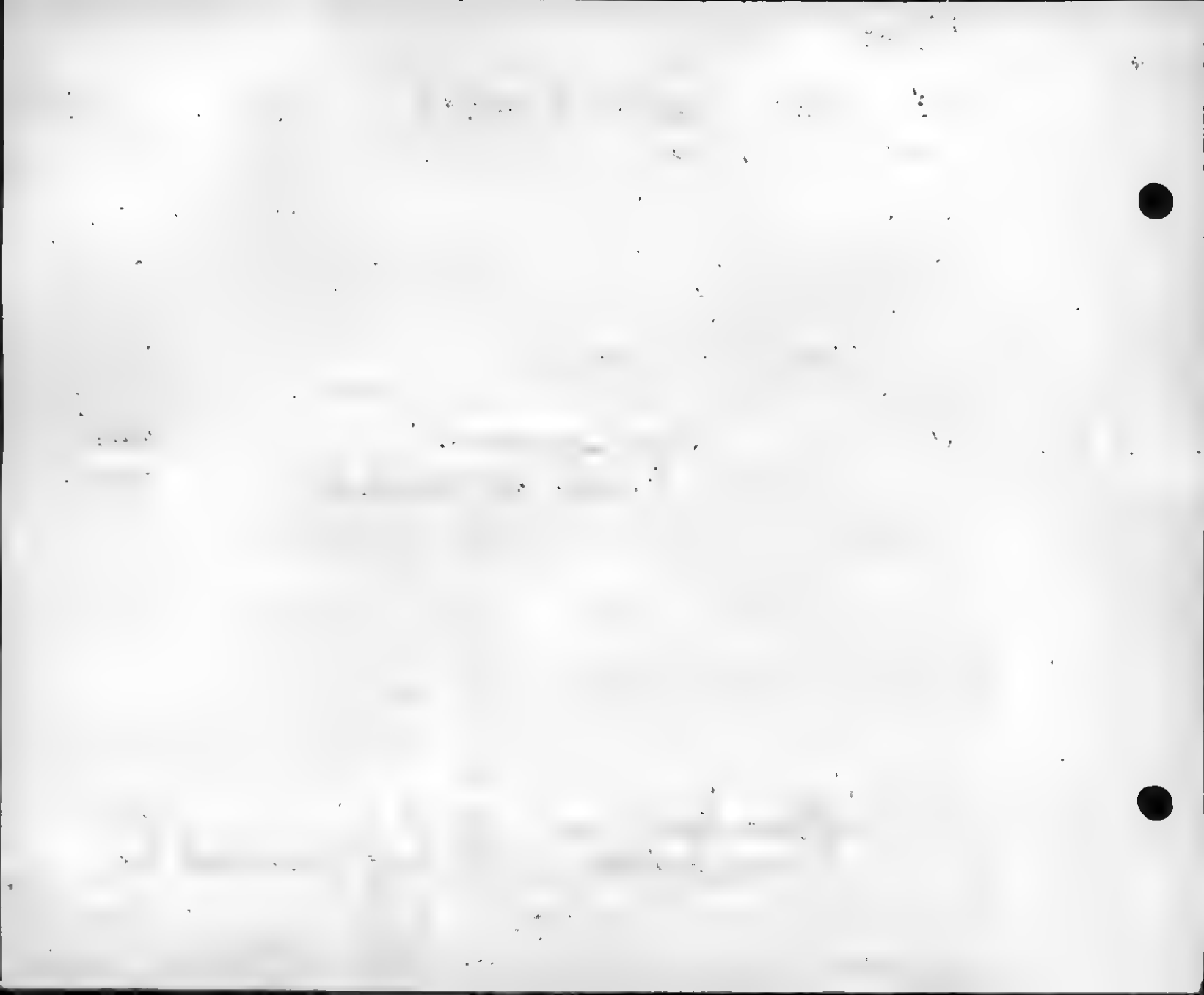
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16356

Item 6, Film 406 11/22/68 km

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) James Archie D. Gregory			2a DATE OF DEATH Month Nov. Day 11 Year 1968			2b HOUR 8:30 AM				
3 SEX Male		4 RACE White		5 DATE OF BIRTH January 1, 1929		6 AGE (In years last birthday) 38 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md				
10. CITY OR TOWN OF DEATH Bowie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7800 Chestnut Ave				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) engineer		12b KIND OF BUSINESS OR INDUSTRY John Center		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b COUNTY P. G.		13c CITY OR TOWN Bowie		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7800 Chestnut Avenue		
14 FATHER'S NAME First Angelo Middle Ali Last Gregory			15. MOTHER'S MAIDEN NAME First Santos Middle Demario Last Gregory							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) yes 1955-1957			16b SOCIAL SECURITY NO. 1955-1957		17. INFORMANT Sarahy Ali Gregory Address 11/11/68					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Cancer of Stomach DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Weeks Several Months										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21a. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE H. James Kurtz MD		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/11/68				
22d. PHYSICIAN'S NAME (Type) H. James Kurtz		22e ADDRESS RFD #1 Glenn Dale Md								
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-14-68		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem		23d LOCATION (City or Town) (County) (State) Clinton PG Md.				
24. FUNERAL DIRECTOR Donaldson Funeral Home Laurel Md		ADDRESS		25a REC'D BY REGISTRAR NOV 18 1968		25b REGISTRAR'S SIGNATURE John Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16323

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1633

1. DECEASED-NAME (Type or print) HARVEY CHARLES DORNEY			2a. DATE OF DEATH Month NOVEMBER Day 13 Year 68			2b. HOUR 2045 M	
3 SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 4 Nov 1912		6 AGE (In years last birthday) 56 YRS	
7a BIRTHPLACE (State or foreign country) OKLAHOMA'S		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE Md.	
10. CITY OR TOWN OF DEATH ANDREWS AIR FORCE BASE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW HOSP		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BOMBER PILOT		12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE ILLINOIS COUNTY RICHLAND		13c CITY OR TOWN OLNEY		13d INSIDE CITY, LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 221 WEST CHESTNUT STREET	
14. FATHER'S NAME First Middle Last HARVEY CHARLES DORNEY JR.			15. MOTHER'S MAIDEN NAME First Middle Last MATILDA AGNES MEHMERT				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		16b. SOCIAL SECURITY NO. 320346932		17. INFORMANT Address MRS DOROTHY A. DORNEY 7405 CHESTERFIELD DR. CAMP SPRINGS MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma of the stomach DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) bowel obstruction							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 25 Sep, 19 68 , to 13 Nov, 19 68 , that (I) (we) last saw the deceased alive on 13 Nov. 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE David A Morowitz, MD		22c. PHYSICIAN'S NAME (Type) DAVID A MOROWITZ		22d. ADDRESS MALCOLM GROW USAF HOSPITAL ANDREWS AFB, WASHINGTON, D.C. 20331		22e. DATE SIGNED 13 Nov. 68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-15-68		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Virginia		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR W W Chambers & Co. 517-11th St. S.E.		25a. REC'D BY REGISTRAR DATE NOV 18 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jones			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove organ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1
45M 1159

16324

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16324

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Philip C. Dorr			2a. DATE OF DEATH Month Nov. Day 30 Year 68			2b. HOUR 6:30 PM		
3 SEX Male		4. RACE Cauc.		5. DATE OF BIRTH 06-19-93		6 AGE (In years last birthday) 75 YRS.		
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges Md.		
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Supt. S.S. Govt.		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Prince Georges Mt. Rainier			13c. CITY OR TOWN 3808 32nd Street		
14. FATHER'S NAME First Middle Last Clarence Dorr			15. MOTHER'S MAIDEN NAME First Middle Last Mary Shattuck					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes WWII			16b. SOCIAL SECURITY NO.		17. INFORMANT Ruby V. Dorr - Alova			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular Fibrillation (3 hrs post surgical) 1530 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 1530 (b) Carcinoma of Cecum DUE TO, OR AS A CONSEQUENCE OF (c) 44 days (d)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Complete Pulmonary Arteriosclerosis, Atherosclerosis								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Mat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from Oct. 14 , 19 68 , to Nov. 30 , 19 68 , that (X) (we) last saw the deceased alive on Nov. 30 , 19 68 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.								
22b. SIGNATURE Jerome Sandler, M. D.			22c. DATE SIGNED 12/1/68			22d. PHYSICIAN'S NAME (Type) Jerome Sandler, M. D.		
23a. BURIAL CREMATION, EMBOVA (Specify)			23b. DATE 12/4/68		23c. NAME OF CEMETERY OR CREMATORY Seagr Hill Cem.		23d. LOCATION (City or Town) (County) (State) Suitland, Md.	
24. FUNERAL DIRECTOR Valley Funeral Home Mt. Rainier Md			ADDRESS		25a. REC'D BY REGISTRAR DEC 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 16325 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16325 </div>																	
1. DECEASED NAME (Type or print)			First Herman			Middle Bradford			Last Dudley			2a. DATE OF DEATH 11-13-68			2b. HOUR 9:25 AM		
3 SEX Male			4 RACE White			5. DATE OF BIRTH 3-15-90			6 AGE (In years last birthday) 78			IF UNDER YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Prince George Md								
10. CITY OR TOWN OF DEATH Riverdale			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mail clerk			12b KIND OF BUSINESS OR INDUSTRY Penna R R								
13a USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) STATE Maryland			13b. COUNTY Prince George			13c CITY OR TOWN W. Hyattsville			13d INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 2011 Oglethorpe St.					
14. FATHER'S NAME First Herman			Middle B.			Last Dudley Sr.			15 MOTHER'S MAIDEN NAME First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			(If yes give war or dates of service)			16b SOCIAL SECURITY NO 579 24 2722			17. INFORMANT Son and Medical Records								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>284x</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												<u>Coronary Heart Failure</u> <u>1 day</u> <u>1.5 hr</u>					
(b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1</u> , 19 <u>68</u> , to <u>Nov 13</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov 13</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>L.W. Malin</u>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 11-13-68		
22d. PHYSICIAN'S NAME (Type) L.W. Malin, M.D.			22e. ADDRESS 440 Queensbury Rd., Riverdale, Md.														
23a. BURIAL (CREMATION, REMOVAL (Specify) Burial			23b. DATE Nov 15, 1968			23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery			23d. LOCATION (City or Town) Colmar Manor Pro Geo			(County) Md.			(State)		
24. FUNERAL DIRECTOR F. Gasch's Sons			ADDRESS Hyattsville, Md.			25a. REC'D BY REGISTRAR DATE NOV 18 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

253



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

18533

DECEASED NAME (Type or print) <u>Emma</u> First <u>D.</u> Middle <u>Duncan</u> Last			2a. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>1968</u>			2b. HOUR <u>3 A.M.</u>	
3 SEX <u>Female</u>		4 RACE <u>Negro</u>		5 DATE OF BIRTH <u>May 6, 1895</u>		6 AGE (In years last birthday) <u>72 YRS.</u>	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Prince George's</u> Md	
10. CITY OR TOWN OF DEATH <u>Cheverly</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Prince George's Gen'l Hosp.</u>		12a. USUAL OCCUPATION (kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Prince George's</u>		13c. CITY OR TOWN <u>Highland Park</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>1202 78th Avenue</u>		14 FATHER'S NAME First Middle Last		15 MOTHER'S MAIDEN NAME First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> right side. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Massive cerebral infarct - right hemisphere - old and new</u> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>332X</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that <u>Dr.</u> (this hospital) attended the deceased from <u>Sept. 27</u> , 19 <u>68</u> , to <u>Nov. 1</u> , 19 <u>68</u> , that <u>he</u> (we) last saw the deceased alive on <u>Nov. 1</u> , 19 <u>68</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>he</u> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Joselito D. Magday, M.D.</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>Nov. 1, 1968</u>			
22d. PHYSICIAN'S NAME (Type) <u>Joselito D. Magday, M. D.</u>				22e. ADDRESS <u>Prince George's General Hosp. Maryland</u>			
23a. BURIAL, CREMATION, REMOVE (Specify)		23b. DATE <u>Nov. 5, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince George's County, Md.</u>	
24. FUNERAL DIRECTOR <u>Brown & Davidson</u> ADDRESS <u>5635 Eads St., N. E.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 6 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

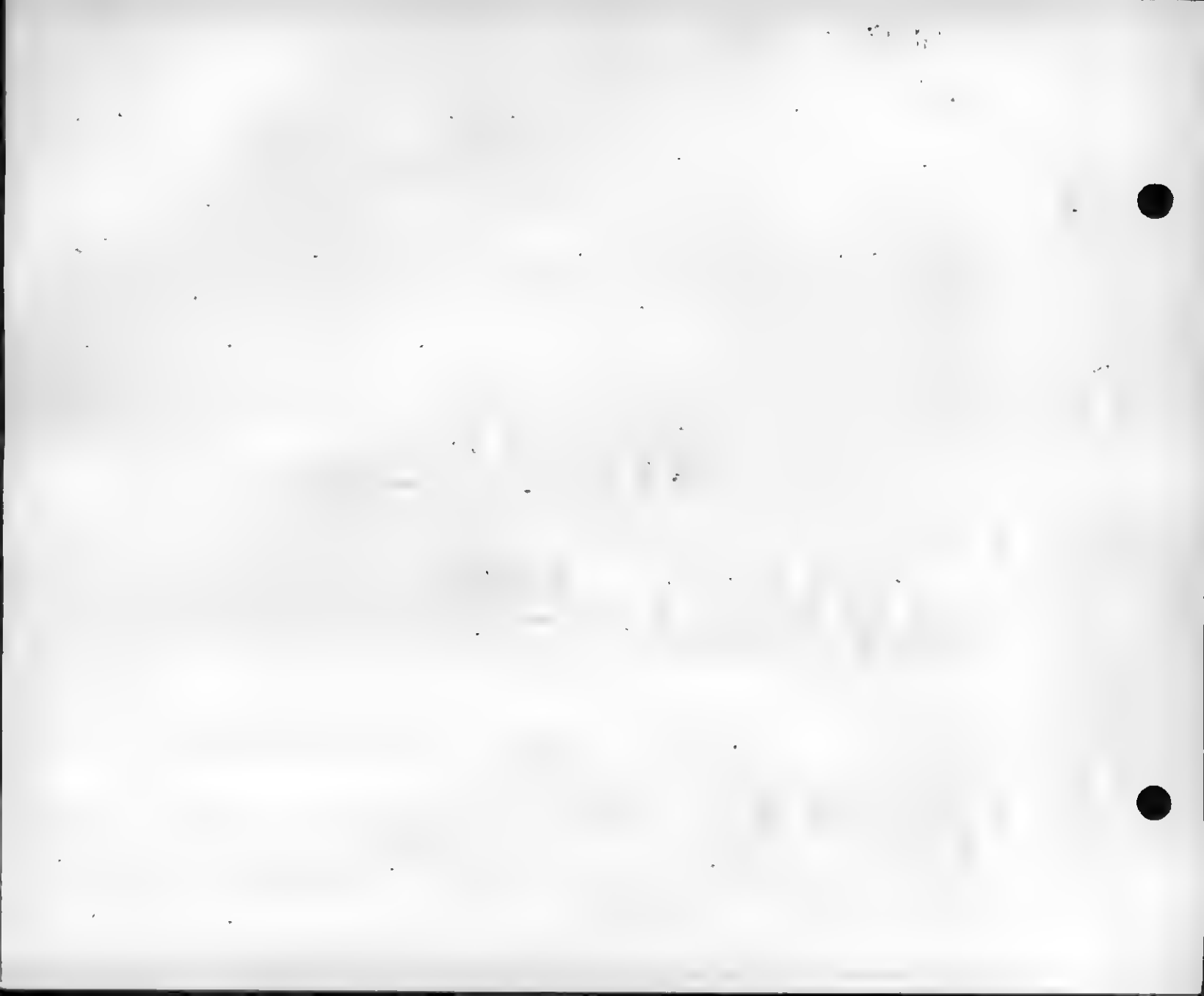
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16326

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

100 0

1. DECEASED-NAME (Type or print) First Middle Last Doris Erickson			2a. DATE OF DEATH Month Day Year 11 19 68			2b. HOUR 9:50a M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5-14-08		6. AGE (In years lost birthday) 60 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Sep. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. COUNTY OF DEATH Prince George Md	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 312 Main St.		14. FATHER'S NAME First Middle Last George V. Ward		15. MOTHER'S MAIDEN NAME First Middle Last Jessie G. Hopper			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Subdural Hematoma, right</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>3375</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <u>Cerebral Confusion, Alcoholic</u>							
19a. DATE OF OPERATION 11/17/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Subdural Hematoma		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med'cal examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Nov. 17, 19 68 to Nov. 19, 19 68, that (I) (we) last saw the deceased alive on Nov. 19 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE B. E. Perez, M.D.				22c. DATE SIGNED Nov. 19, 1968		22d. PHYSICIAN'S NAME (Type) B. E. Perez, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-21-68		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Cemetery Md		23d. LOCATION (City or Town) (County) (State) Laurel Md	
24. FUNERAL DIRECTOR Charles J. Judge				25a. REC'D BY REGISTRAR DATE NOV 26 1968		25b. REGISTRAR'S SIGNATURE Charles J. Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 409 1-29-68 MARYLAND STATE DEPARTMENT OF HEALTH 16327 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) Maurita E Fattorini						2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year 11-8-68			2b HOJR 11:00am		
3 SEX Female	4 RACE White	5 DATE OF BIRTH 5-28-1911	6 AGE (In years last birthday) 57 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		2c DATE PRONOUNCED DEAD Month 11 Day 9 Year 68		2d HOUR 12pm	
7a BIRTHPLACE (State or foreign country) Wash., D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md					
10 CITY OR TOWN OF DEATH Chesverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b KIND OF BUSINESS OR INDUSTRY own home		
13a USUAL RESIDENCE (Where deceased lived, if not in hospital: Residence before admission) STATE Maryland COUNTY Prince George's			13c CITY OR TOWN Hyattsville		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 2215 University Blvd.				
14 FATHER'S NAME First George Middle W. Last Gordon				15 MOTHER'S MAIDEN NAME First Mabel Middle W. Last Perkins							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No			16b SOCIAL SECURITY NO 578-05-8426		17. INFORMANT ADDRESS Sil. Spr. Md. Mrs. Mabel W. Gordon 1011 Tracy Drive						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Inactive pulmonary tuberculosis											
19a. DATE OF OPERATION 4-20-68				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Kehoe M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 11-11-68			
EXAMINER'S NAME (Type) John Kehoe MD				RIVERDALE, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-13-1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland Pr. Geos. Maryland				
24. FUNERAL DIRECTOR Julius J.W. Lee ADDRESS Sil. Spr. Md.				25a. REC'D BY REGISTRAR Warner E. Pumphrey, Inc. 8434 Ga. Avenue		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 14 1968			



FOR STATE HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

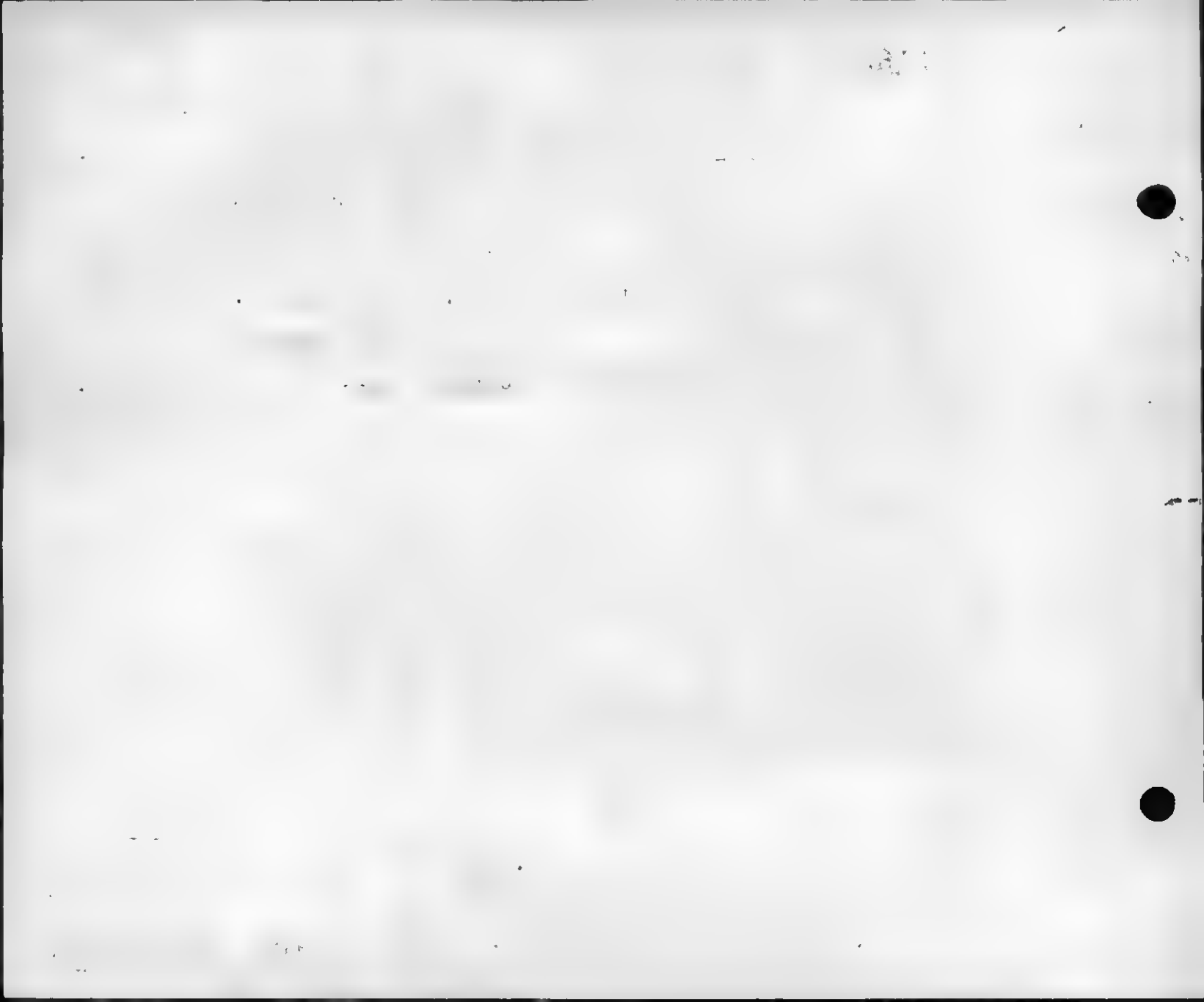
Items 18 & 22a Film 407 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16323

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16342

1 DECEASED NAME (Type or Print) Onard			First Middle Last			2a DATE KNOWN OF DEATH MATED 11-2-68			2b HOUR 19 ? M			
3 SEX Male		4 RACE White		5 DATE OF BIRTH 12-27-1926		6 AGE (in years last birthday) 41 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Kentucky			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 COUNTY OF DEATH Prince George's Md			
10 CITY OR TOWN OF DEATH Cheverly				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Repairman			12b KIND OF BUSINESS OR INDUSTRY Wax museum	
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before) Maryland				13b CITY OR TOWN Prince George's Capitol Hgts.				13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 836 57th. Avenue		
14. FATHER'S NAME Arnold Fields						15 MOTHER'S MAIDEN NAME Zettie Sullivan						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16b SOCIAL SECURITY NO (If yes give war or dates of service) WW II 405 22 1992		17 INFORMANT Joyce O'Neal			ADDRESS Forestville, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Severe coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Unknown										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a DATE OF OPERATION 4				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b DATE SIGNED 11-4-68			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE Nov 7, 1968		23c NAME OF CEMETERY OR CREMATORY Mountain View Memorial				23d LOCATION (City or Town) (County) (State) Colburn Kentucky				
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.						25a REC'D BY REGISTRAR DATE NOV 7 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

16328

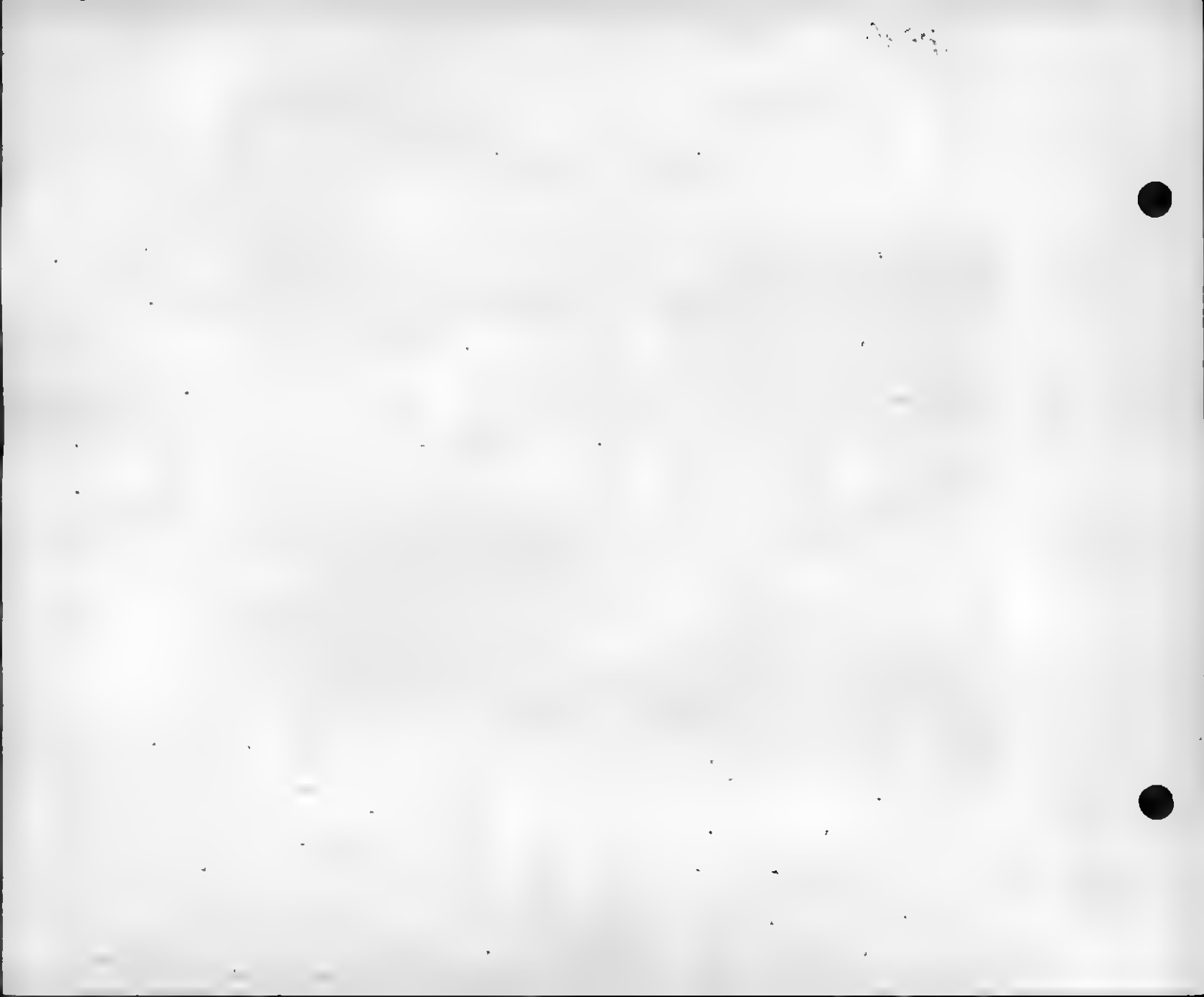
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16343

1 DECEASED NAME (Type or print) Charles		First	Middle	Last	2a DATE OF DEATH 11 Month 3 Day 68 Year		2b HOUR 1:35 PM	
3 SEX MALE		4 RACE white		5 DATE OF BIRTH 6/20/1883		6 AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) Md		7b CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md		
10 CITY OR TOWN OF DEATH Hyattsville, Md		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Madison Manor Nursing Home 5801 42nd Ave		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Pressman		12b KIND OF BUSINESS OR INDUSTRY U S Govt.		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b COUNTY Pro George's		13c CITY OR TOWN Riverdale		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 6209 57th ave.
14. FATHER'S NAME First Middle Last John Ford				15. MOTHER'S MAIDEN NAME First Middle Last Anna Gumpf				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO 214533 156		17 INFORMANT Address John B Ford Riverdale, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma, generalized 1538 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Colon Condit.ans. if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Carcinoma of Colon DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Colon								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years 6 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1538								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1964 , to 11-4 , 19 68 , that (I) (we) last saw the deceased alive on 10-31- 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.								
22b. SIGNATURE Donald C. Edgren				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 11-4-68		
22d. PHYSICIAN'S NAME (Type) DONALD C. EDGREN				22e ADDRESS 3500 East-West Highway Hyattsville, Md				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Nov 6, 1968		23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md		
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville Md.				25a. REC'D BY REGISTRAR DATE NOV 7 1968		25b REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

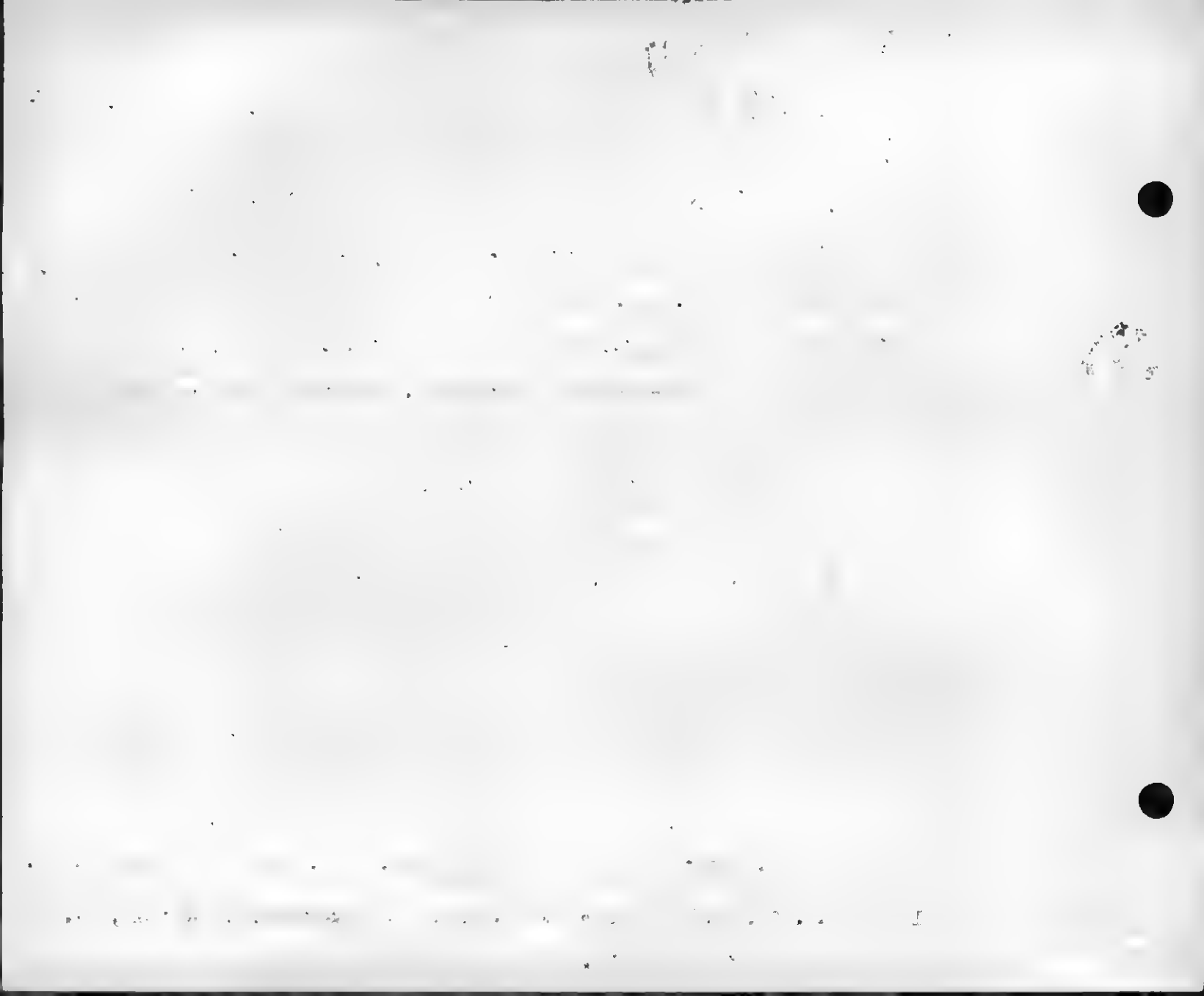
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16330

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16330

1. DECEASED-NAME (Type or print) <i>Louis S. Forsythe</i>			2a. DATE OF DEATH Month <i>11</i> Day <i>20</i> Year <i>68</i>			2b. HOUR <i>3:50 A.M.</i>	
3. SEX <i>MALE</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>10-30-95</i>		6. AGE (In years last birthday) <i>73</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince Georges</i> Md	
10. CITY OR TOWN OF DEATH <i>College Park - Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Greenbelt Conv. Center</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Book Binder</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Printing Co.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Pr. Geo.</i>		13c. CITY OR TOWN <i>Greenbelt</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>8 B Southway</i>		13f. CITY OR TOWN <i>Greenbelt Md.</i>		13g. STATE <i>Md.</i>		13h. ZIP CODE <i>20775</i>	
14. FATHER'S NAME First Middle Last <i>Edward E. Forsythe</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Caroline Collins</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>229-10-8627</i>		17. INFORMANT <i>Margaret H. Forsythe - Same as # 13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>41</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>41</i> (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis Generalized</i> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Complete heart block with underlying pacemaker</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9 days</i>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>10/24/68</i> to <i>11/20/68</i> , that (I) (we) last saw the deceased alive on <i>11/19/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Norman P. Fogarty</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>11/20/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Norman P. Fogarty</i>		22e. ADDRESS <i>820-Univ. Blvd. East, Silver Spring, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Nov. 22, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Olive Branch Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Portsmouth Norfolk, Va.</i>	
24. FUNERAL DIRECTOR <i>F. Gasch's Sons Hyattsville, Md.</i>				25a. REC'D BY REGISTRAR <i>DATE NOV 21 1968</i>		25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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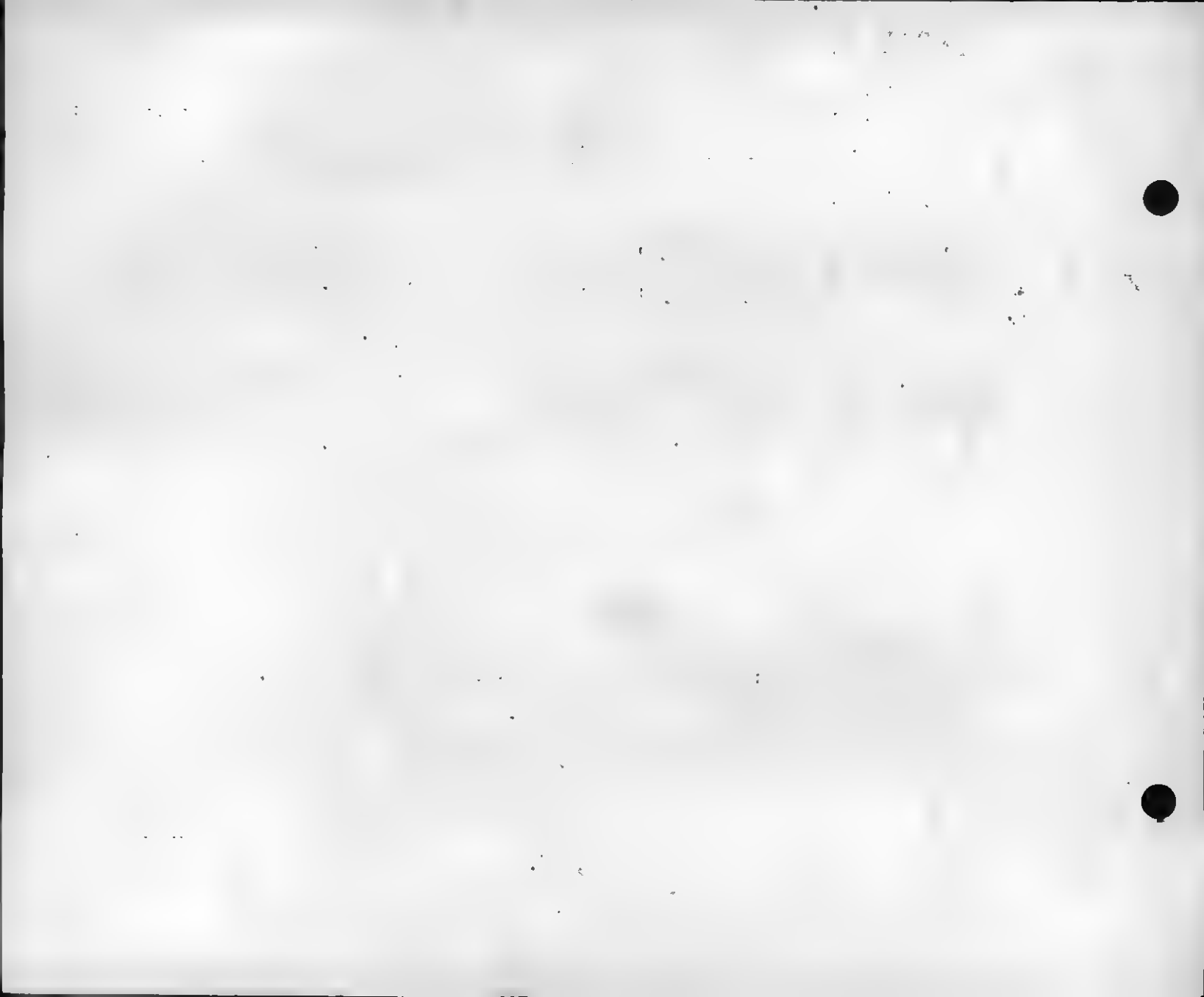
16332

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10340

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH				2b HOUR	
Walnut						Fox		DATE ESTIMATED <input checked="" type="checkbox"/> 11-13-68				9 6:00am	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR		
Male	White	11-16-1904		63 YRS	MONTHS	DAYS	HOURS	MIN	11 13 68		12:00pm		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH							
VIRGINIA		U.S.				Prince George's Md.							
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY	
Riverdale				Chamber's Funeral Home				INSERTED				POST NEWS PAPER	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) - STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland				Prince George's		Hillside		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5111 Marlboro Pike			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)							
UNKNOWN				UNKNOWN		16b SOCIAL SECURITY NO. 22-6-2160384							
17 INFORMANT				18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
				PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5th. degree burns of 100 % of body surface									
				DUE TO, OR AS A CONSEQUENCE OF									
				(b)									
				DUE TO, OR AS A CONSEQUENCE OF									
				(c)									
				PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
				19a DATE OF OPERATION									
				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?									
				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
				5:43am 11-13-1968				Trapped in house fire.					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street factory, office building, etc.)				21f LOCATION Street or R.F.D. No					
				home				same as #13					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural Causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				22b DATE SIGNED				11-14-68					
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				DEPUTY MEDICAL EXAMINER					
EXAMINER'S NAME (Type)				John Kehoe MD Riverdale, Md.				ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY					
BURIAL				11-20-1968				BALTIMORE NATH CEM					
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR					
WILL CHAMBERS & RIVERDALE, MD								25b REGISTRAR'S SIGNATURE					
								DATE NOV 25 1968					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form VM-3. Page 5 may be retained for your files.

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Items 18&22a Film 407 MARYLAND STATE DEPARTMENT OF HEALTH
1-26-60ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)		Elizabeth Louise Gallagher		2a DATE KNOWN OF DEATH		Month <input checked="" type="checkbox"/> Day 11-3-68 Year 1950		2b HOUR	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR	7 UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR	
Female	White	3-3-1921	47 YRS	MONTHS	DAYS	MONTHS	MIN	Month 11 Day 3 Year 68	19:32am
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Pa		USA				Prince George's		Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George Hospital		Housewife		home			
13a USUAL RESIDENCE (Where deceased resided, if institution, residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Maryland		Prince George's		Bowie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12510 Millstream Drive	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT	
First Middle Last		First Middle Last		no		168 12 8766		Edward P Gallagher	
William Mc Nulty		Mary Nash						ADDRESS	
								Bowie, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Heart failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		Arteriosclerotic heart disease		Unk			
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b. DATE SIGNED		11-4-68			
John Kehoe MD		Riverdale, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Nov 6, 1968		Arlington National		Arlington Arlington Va			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
F. Gasch's Sons		Hyattsville, Md.		NOV 7 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item# 4, 07 12 3, 68 kk MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16332

Items# 4, 7b, 14, 15, Film# 112700

CERTIFICATE OF DEATH

1034

1. DECEASED-NAME (Type or print) First <u>Shoosan</u> Middle <u>E.</u> Last <u>Ghazarian</u>			2a. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1968</u>		2b. HOUR <u>5:28</u>
3. SEX <u>Female</u>	4. RACE <u>Caucasian</u>	5. DATE OF BIRTH <u>4/5/1902</u>		6. AGE (In years last birthday) <u>66</u> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <u>Tabriz, Iran</u>	7b. CITIZEN OF WHAT COUNTRY? <u>Iran</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Prince Georges</u> Md.		
10. CITY OR TOWN OF DEATH <u>Riverdale</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>E. Leland Memorial</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>	13b. COUNTY <u>P. G.</u>	13c. CITY OR TOWN <u>Brentwood</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <u>452 - 30th St.</u>	
14. FATHER'S NAME First <u>Baghdasar</u> Middle <u>Acopian</u> Last <u>Unknown</u>		15. MOTHER'S MAIDEN NAME First <u>Marian</u> Middle <u>Unknown</u> Last <u>Unknown</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>NO</u>		16b. SOCIAL SECURITY NO <u>-</u>		17. INFORMANT <u>Ivan Luka</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Uremia</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 day</u> <u>5 day</u> <u>6 day</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-9-68</u> , to <u>11-15-68</u> , that (I) (we) last saw the deceased alive on <u>11-15-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Shoosan</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <u>JOHANNES SAKAKYAN</u>		22e. ADDRESS <u>6001 Cambridge Rd Charlestown</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11/19/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Cem.</u>	
23d. LOCATION (City or Town) (County) (State) <u>Arlington, Mass.</u>					
24. FUNERAL DIRECTOR <u>Malley's Funeral Home</u>		ADDRESS <u>Mt. Rainier</u>		25a. REC'D BY REGISTRAR <u>DATE Nov 25 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16334

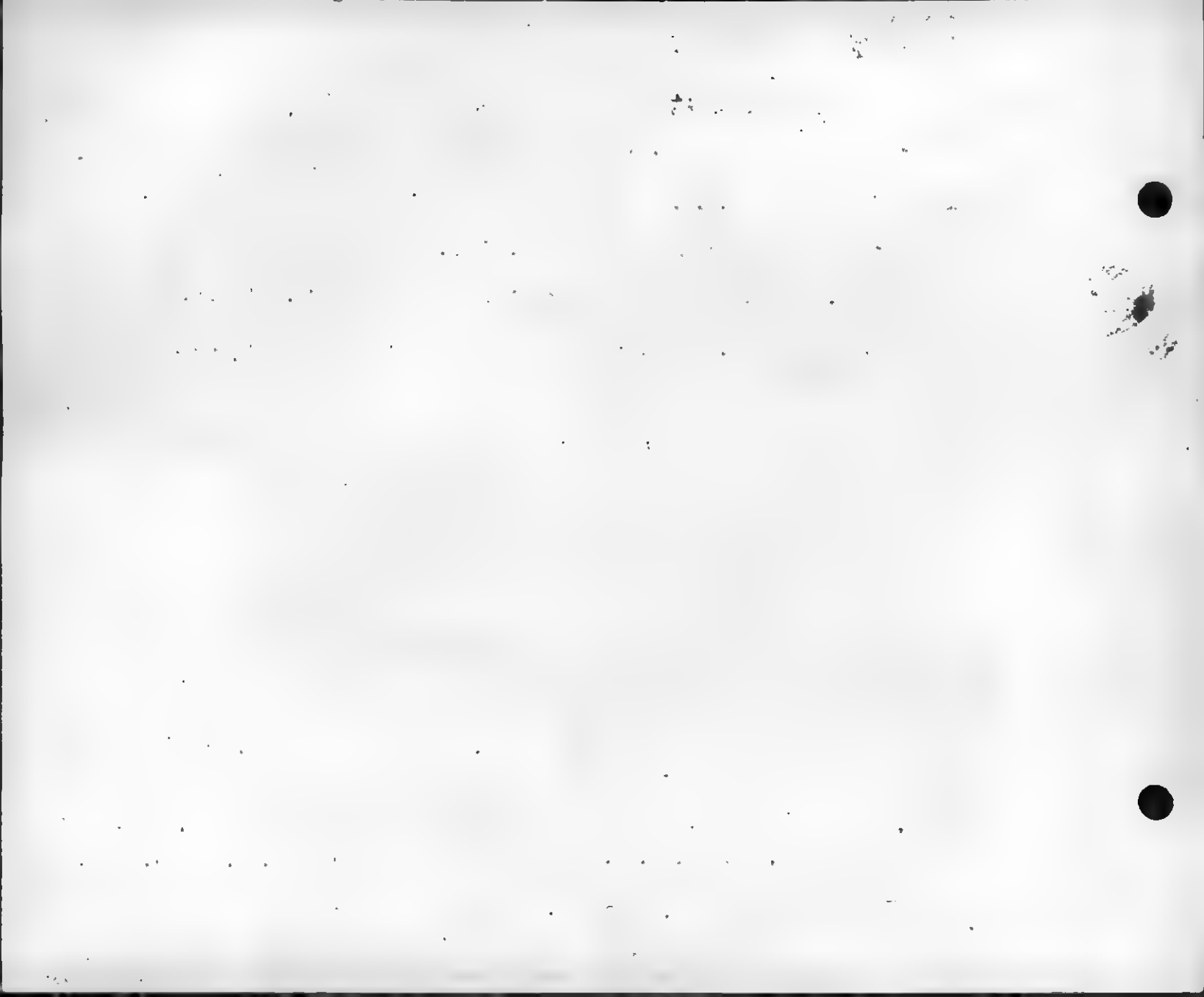
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 1, Film 3400 1/13/69 enc

CERTIFICATE OF DEATH

16348

1. DECEASED NAME (Type or print) Baby/Boy John Ernest Gibbs			2a. DATE OF DEATH Month Nov. Day 16 Year 68			2b. HOUR 10:00 P.M.	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH 11-16-68		6. AGE (In years lost birthday) YRS. 27	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. Prince Georges		13c. CITY OR TOWN Edgewater		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Rt. 3, Box 686	
14. FATHER'S NAME First Middle Last William H. Gibbs			15. MOTHER'S MAIDEN NAME First Middle Last Mary Elizabeth Burdette				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HYDROPS. FETALIS. CONCENTRAL 7740 DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Rh INCOMPATIBILITY. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1100							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from Nov. 16 , 19 68 , to Nov. 16 , 19 68 , that (I) (we) lost saw the deceased alive on Nov. 16 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. E. Altman				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/15/68	
22d. PHYSICIAN'S NAME (Type) Harry E. Altman, M. D.				22e. ADDRESS 2025 Eye Street, N. W., Wash., DC 20006			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE 11/23/68		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. General Hosp.		23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland	
24. FUNERAL DIRECTOR HARRY W. PENN, JR., ADMINISTRATOR				25a. REC'D BY REGISTRAR DATE NOV 29 1968		25b. REGISTRAR'S SIGNATURE f Charles Judge	



16335

CERTIFICATE OF DEATH

16335

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
MARIA (Marij) NMN				GILBERT	November 27, 1968		3:20 P	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
Female	White		July 16, 1919		49 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penn.	U.S.A.				Prince George Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Camp Springs		Andrew's Air Force Base		Sales Clerk		Sales		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Penn.		Lackawanna		Scranton		1407 Dorothy Street		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
William				D'Amico	unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No		202-42-4032		Mr. Daniel N. Gilbert same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY & VASCULAR COLLAPSE</u> <u>34X7</u> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>BRAXN STEN DAMAGE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>27 NOV, 1968</u> to <u>27 NOV, 1968</u> that (I) (we) last saw the deceased alive on <u>27 NOV 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS				
Arwin Arthur M.D.		Andrew's Air Force Base Camp Spr., Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		11-30-68	Cathedral Cemetery		Scranton Lackawanna Penna.			
24. FUNERAL DIRECTOR		M. Andrew D. Duwall		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Warner E. Humphrey Inc. 8434 Ga. Ave. S.S. Md.		M. G. Duwall		DATE DEC 3 1968		Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death. This certifies that Dr. Keegoe, Medical Examiner of Prince George's county notified and approved.



16336

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First Florence	Middle E	Last Goette	2a. DATE OF DEATH Month November			Day 23	Year 1968	2b. HOUR 4:35 M
3. SEX Female		4. RACE White		5. DATE OF BIRTH September 26, 1881		6. AGE (in years last birthday) 87 YRS		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Canada		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.				
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY home				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8618 Kiama Road		
14. FATHER'S NAME First George		Middle Knox		Last Mary		15. MOTHER'S MAIDEN NAME First Mary		Middle Brogan		Last Brogan
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give year or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Sacred Heart Home, Hyattsville, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS & MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>42</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 years</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>11-23</u> , 1968, to <u>11-23</u> , 1968, that (I) (we) last saw the deceased alive on <u>11-23</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Thomas F Collins M.D.</u>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>11-23-68</u>				
22d. PHYSICIAN'S NAME (Type) THOMAS F COLLINS		22e. ADDRESS 322 - HAINES								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/26/68		23c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery		23d. LOCATION (City or Town) Savannah, Georgia		(County)		(State)
24. FUNERAL DIRECTOR <u>Donald J. H.</u>		ADDRESS <u>Laurel Md.</u>		25a. REC'D BY REGISTRAR DATE NOV 29 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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16337

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16351

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOUR		
Jessie		B.	Graham		Month 11 Day 23 Year 1968		11:40PM		
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		
Female	Negro		11/27/1898		69 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
S. C.	U.S.A.				Prince Georges Md.				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Glenn Dale		Glenn Dale Hospital		unknown - retired		unknown			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
				Wash., D.C.				1432 R St., N. W.	
14. FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last					
Unknown				Ada Mobley					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT Address					
No		unknown		Decedent					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4120 X (b) DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive and arteriosclerotic cardiovascular disease years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus with diabetic nephrosclerosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that the (this hospital) attended the deceased from 10/18/1968, to 11/23/1968, that we (we) last saw the deceased alive on 11/23/1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, the (we) (did) (did not) view the body after death.									
22b SIGNATURE				DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 11/23/68	
22d PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22e ADDRESS Glenn Dale Hospital Glenn Dale, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11/29/1968		23c NAME OF CEMETERY OR CREMATORY Arlington		23d LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR Ernest Jarvis Co., Inc. 1432 U St. N.W. Address				25a REC'D BY REGISTRAR DATE NOV 29 1968		25b REG STRAR'S SIGNATURE Charles Judge			



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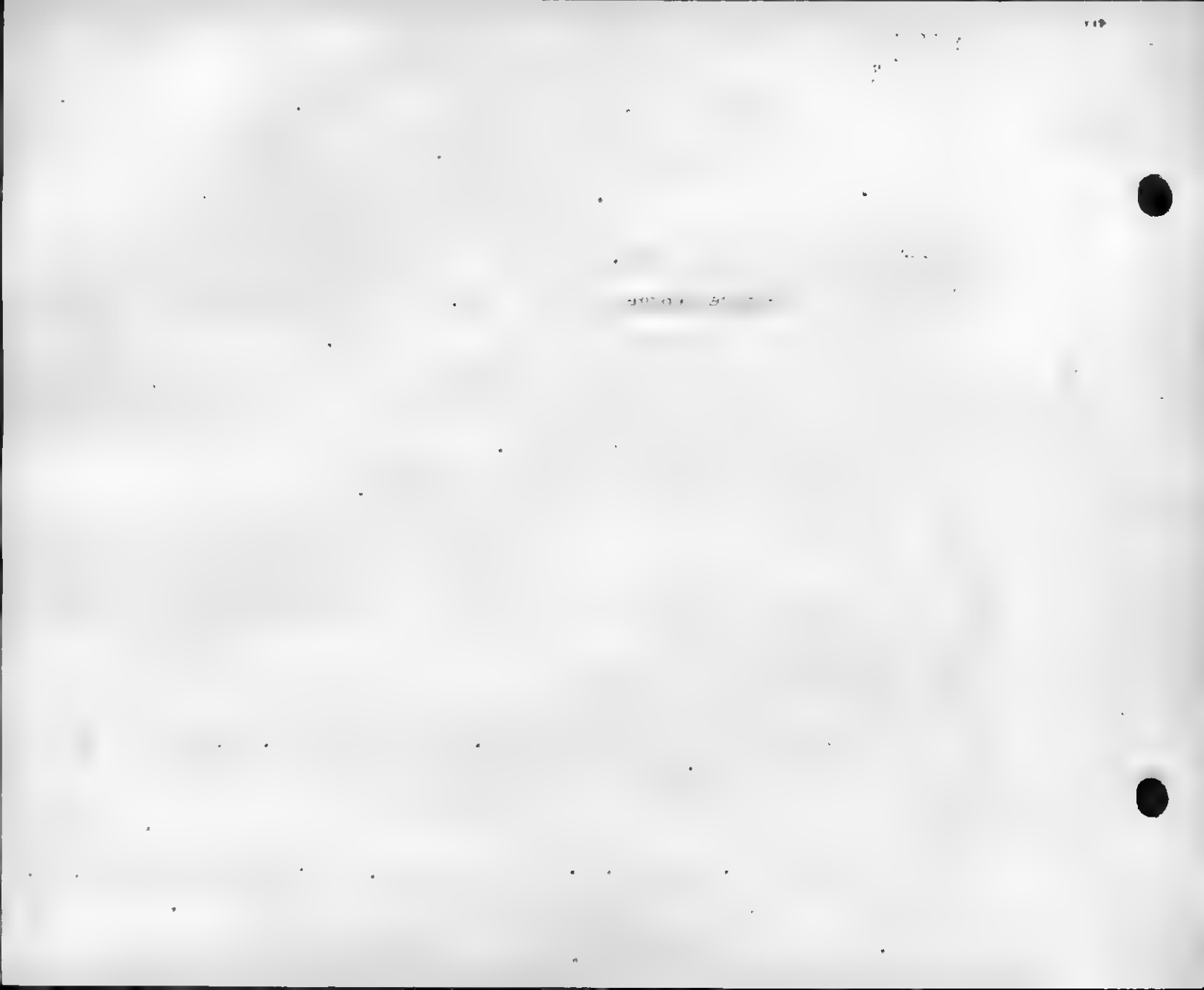
16338

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1635

1 DECEASED NAME (Type or print) Leonard K. Grant		2a DATE OF DEATH Nov. Month 28, Day 1968		2b HOUR 7:25P	
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH Sept. 9, 1895	6. AGE (In years last birthday) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maine	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md		
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Bookbinder	12b. KIND OF BUSINESS OR INDUSTRY U. S. Gov. Retired		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland	13b. CITY Prince George's Forest Hgts.	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 315 Sachem Drive		
14. FATHER'S NAME First Middle Last Fre Grant	15. MOTHER'S MAIDEN NAME First Middle Last Lillie M. Reed				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (specify) <input type="checkbox"/> No (unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address Howard L. Grant 315 Sachem Dr. Forest Hgts			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia. 2381 DUE TO, OR AS A CONSEQUENCE OF (b) Brain Tumor (Pituitary gland). DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. ALTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (a) (this hospital) attended the deceased from Nov. 10, 1968 to Nov. 28, 1968 , that (we) last saw the deceased alive on Nov. 28, 1968 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) not view the body after death.					
22b. SIGNATURE <i>Arnold G. Brody</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED Nov. 28, 1968	
22d. PHYSICIAN'S NAME (Type) Arnold G. Brody, M. D.				22e. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md.	
23a. BURIAL, CREMATION, REMOVAL Interment	23b. DATE Dec. 2, 1968	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland Md.		
24. FUNERAL DIRECTOR Robert E. Wilhelm		ADDRESS 4308 Suitland Road		25a. REC'D BY REGISTRAR DEC 3 1968	
				25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>	

VA 11-45M



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-101. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH MATED		2b. HOUR	
Anne Fagan Grau						11-7-68 19 PM		M	
3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	7-24-1913	55 YRS			Month 11 Day 8 Year 68		19:30 PM M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
						Prince George's Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
College Park			4604 Amburst Drive						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland			Prince George's College Park			YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
								4604 Amburst Drive	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> DUE TO, OR AS A CONSEQUENCE OF <u>Closed in refrigerator</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (i)									
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?									
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 11-7-19 68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) self.			
						Sat in refrigerator and closed door behind			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) kitchen of home			21f. LOCATION Street or R.F.D. No. City or Town County State same as # 13			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
John Kehoe MD			Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		11-9-68	
ADDRESS			23a. LOCATION (City or Town) (County) (State)			23b. REC'D BY REGISTRAR			
						23c. REGISTRAR'S SIGNATURE			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
			NOV 14 1968			Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4)
304 REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
16340 Form 1, File 3407 12/3/68 km CERTIFICATE OF DEATH 1635												
1. DECEASED NAME (Type or print) First Middle Last ELSIE GREENFIELD			2a. DATE OF DEATH Month Day Year NOVEMBER 9 1968			2b. HOUR Min 55						
3. SEX F		4. RACE C Negro		5. DATE OF BIRTH 1-28-'94		6. AGE (In years last birthday) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS 9 14		IF UNDER 24 HRS HOURS MIN 55		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PR. GEORGES Md						
10. CITY OR TOWN OF DEATH CLINTON MD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PINEVIEW GARDENS			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD			13b. COUNTY 1		13c. CITY OR TOWN WALDORF		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. 3 BOX 456			
14. FATHER'S NAME First Middle Last JOHN HENRY GREENFIELD			15. MOTHER'S MAIDEN NAME First Middle Last JANE ALBERTA WASHINGTON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or [unknown] (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 211-216-14		17. INFORMANT MRS. ERNEST MARSHALL			Address WALDORF MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse 431.0 DUE TO, OR AS A CONSEQUENCE OF Condit ans, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Hypertensive Disease												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) RT. Hemiplegia Diabetes Mellitus												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE Alfred R. Lapin MD			22c. DATE SIGNED Nov 9, 1968			22d. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN, MD			22e. ADDRESS CLINTON, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 11/13/68			23c. NAME OF CEMETERY OR CREMATORY St. Peter's Church			23d. LOCATION (City or Town) (County) (State) Waldorf Charles Md.			
24. FUNERAL DIRECTOR Martell Adams			ADDRESS Aguasca, Md.			25a. REC'D BY REGISTRAR NOV 15 1968			25b. REGISTRAR'S SIGNATURE J. Charles Judge			



MDARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1634

1965

1. DECEASED-NAME (Type or print) Louis		First Middle Last Haas		2a. DATE OF DEATH Month November Day 30 Year 1968		2b. HOUR 2:30 PM	
3 SEX Male		4. RACE White		5. DATE OF BIRTH Jan. 12, 1905		6. AGE (In years lost birthday) 63 YRS.	
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges Md.	
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retail Merchant		12b. KIND OF BUSINESS OR INDUSTRY Hardware	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIM. TST? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 5600 54th Avenue		14 FATHER'S NAME First Middle Last Joseph H. Haas		15. MOTHER'S MAIDEN NAME First Middle Last Mary ? ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> No		16b. SOCIAL SECURITY NO 577-48-1549		17. INFORMANT Jean Haas,		Address Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H-V Heart Block (Cardiac Arrest) 15 minutes DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardio-Vascular Disease Undetermined DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arterio-sclerosis Undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 44-58							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIB. TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebral Thrombosis Occlusive Vascular Disease, Carotid Arteries, bilateral (old) 1963							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June 27, 1963 to Nov 30 1968 that (I) (we) last saw the deceased alive on Nov 23 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE George L Ball		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Dec 1, 1968	
22d. PHYSICIAN'S NAME (Type) George L Ball		22e. ADDRESS 10630 Georgia Ave Silver Spring Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-3-1968		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Md.	
24. FUNERAL DIRECTOR Coldrey Funeral Home		ADDRESS 4217 9th St. N.W. Washington D.C.		25a. REC'D BY REGISTRAR DEC 6 1968		25b. REGISTRAR'S SIGNATURE J. Charles Young	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Examiner P. G. Cornaby, D.C. Keeney, can be reached concerning this case - who authorized me to sign this certificate.



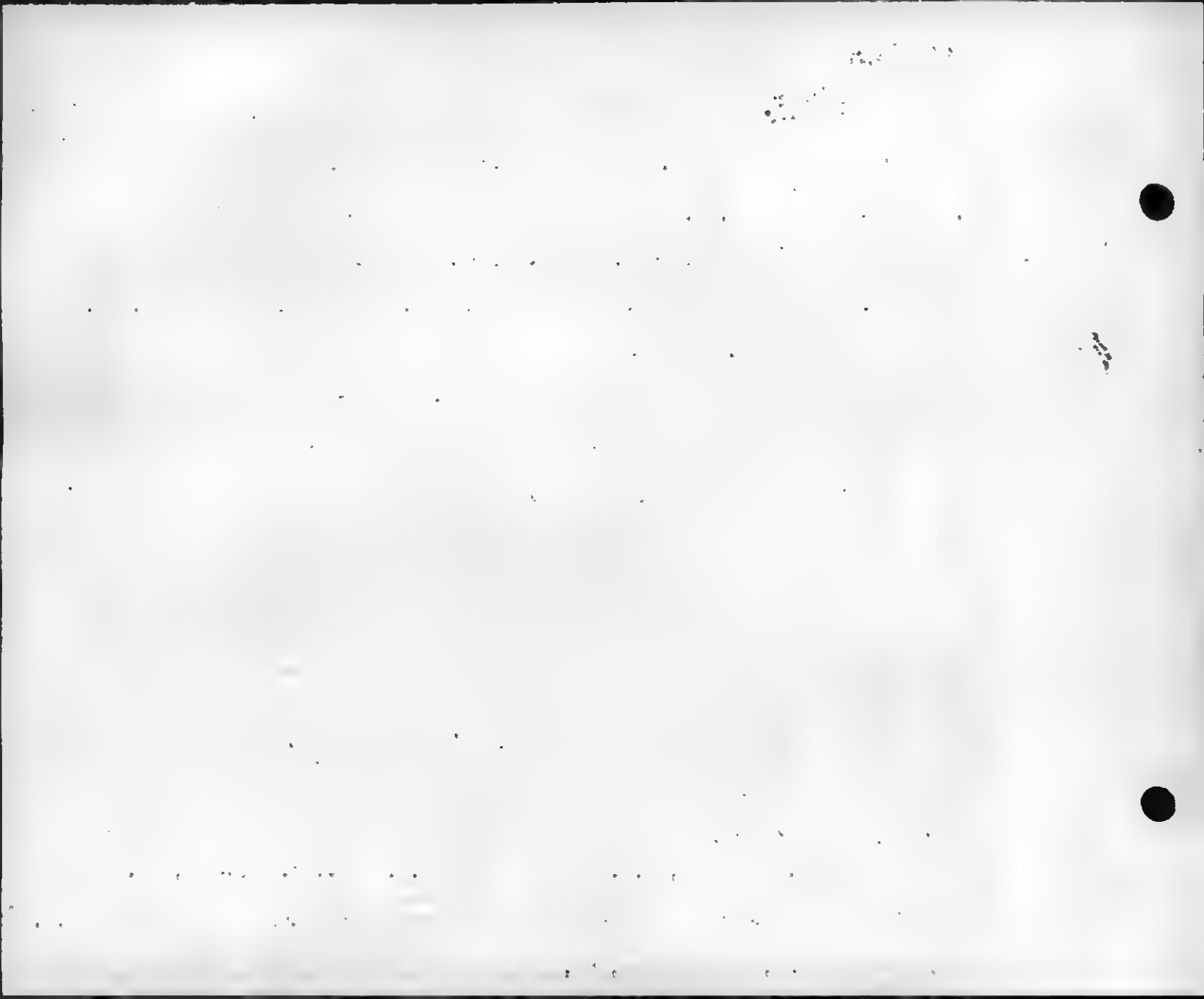
Item 6 Film 407 12/5/68 kh
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16342

16350

1 DECEASED NAME (Type or print)			First MARY Middle ELIZABETH Last HAIRE			2a DATE OF DEATH Month 11 Day 22 Year 1968			2b HOUR 12:01 P.M.		
3 SEX FEMALE			4 RACE CAU.			5. DATE OF BIRTH 29 JUNE 1891			6 AGE (In years last birthday) 76 YRS.		
7a BIRTHPLACE (State or foreign country) So. CAROLINA			7b. CITIZEN OF WHAT COUNTRY? U. S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH PRINCE GEORGE Md		
10 CITY OR TOWN OF DEATH CHEVERLY			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) PRINCE GEO. GENERAL HOSP.			12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.			13b COUNTY PRINCE GEO.			13c CITY OR TOWN DISTRICT HEIGHTS			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last Jackson B. Caston			15. MOTHER'S MAIDEN NAME First Middle Last Ida Young			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO		
17 INFORMANT James W. Haire - Same as # 13			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>acute thrombosis of right coronary artery</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs 2 yrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7201											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1964, 19, to 11/22/68, 19, that (I) (we) last saw the deceased alive on 11/22/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>Leon R. Levitsky</i>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED 11-23-68		
22d. PHYSICIAN'S NAME (Type) Leon R. Levitsky, M.D.			22e. ADDRESS 3408 R.I. Ave., Mt. Rainier, Md.								
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 11-26-68			23c NAME OF CEMETERY OR CREMATOR Bethlehem Baptist Church			23d. LOCATION (City or Town) (County) (State) Lancaster Lancaster S.C.		
24. FUNERAL DIRECTOR F. Gasch & Sons, Hyattsville, Md.			ADDRESS			25a. REC'D BY REGISTRAR DATE NOV 27 1968			25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>		

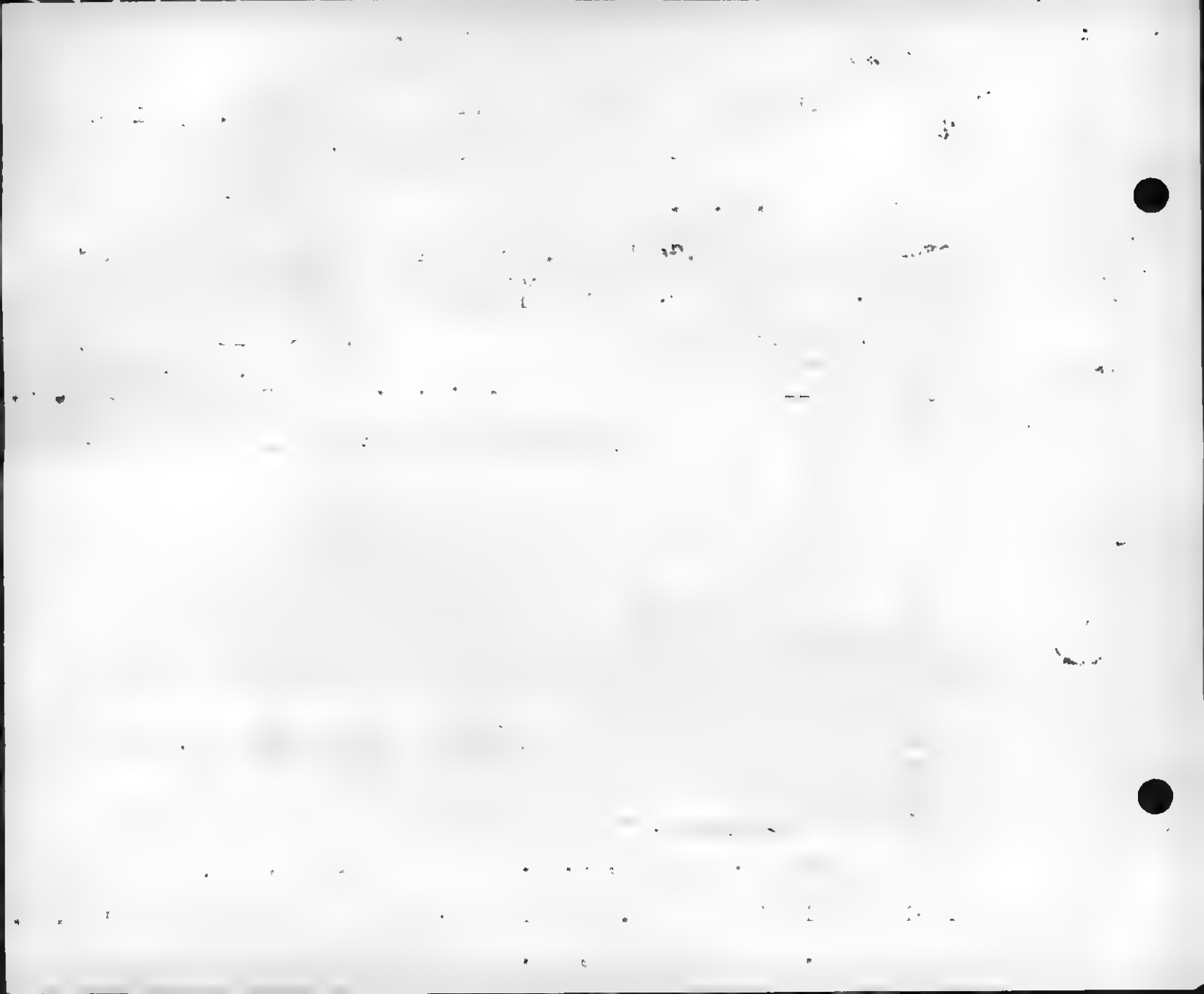
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16343										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16351																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last Alice Harris Hall										Month Day Year Nov. 1, 1968										10:54 AM																													
3. SEX Female										4. RACE White										5. DATE OF BIRTH Feb. 14, 1888										6. AGE (In years last birthday) 80 YRS. MONTHS DAYS HOURS MIN																			
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U. S. A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Prince Georges Md.																			
10. CITY OR TOWN OF DEATH Cheverly										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo's Gen. Hospital										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife										12b. KIND OF BUSINESS OR INDUSTRY Own Home																			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.										13b. COUNTY Pr. Geo's										13c. CITY OR TOWN Upper Marlboro										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER Main Street									
14. FATHER'S NAME First Middle Last Benjamin Frances Harris										15. MOTHER'S MAIDEN NAME First Middle Last Leonore -- Rainier										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/> (If yes give war or dates of service) No										16b. SOCIAL SECURITY NO. --										17. INFORMANT Mrs. Mary H. Tucker-Main Street Upper Marlboro, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) 3 weeks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 1300 , 19 68 , to 1 hr , 19 68 , that (I) (we) last saw the deceased alive on 1 hr , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Robert B. Sasscer										22c. DATE SIGNED 11/1/68																													
22d. PHYSICIAN'S NAME (Type) Robert B. Sasscer, M. D.										22e. ADDRESS Upper Marlboro, Maryland 20870																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 11/4/68										23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery										23d. LOCATION (City or Town) (County) (State) Upper Marlboro PrGeo. Md.																			
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.										25a. REC'D BY REGISTRAR NOV 12 1968										25b. REGISTRAR'S SIGNATURE Charles Judge																													



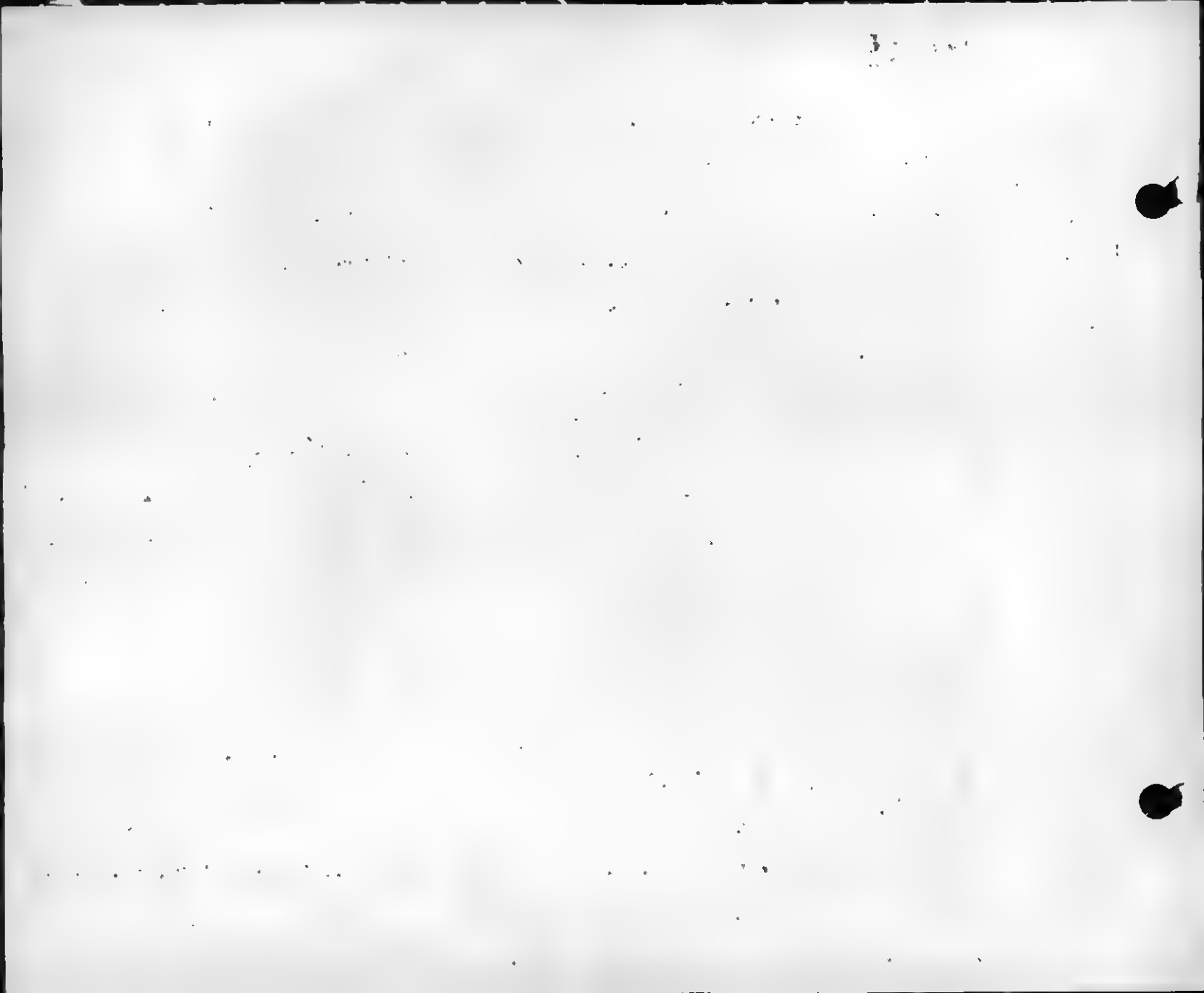
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital and completely filled in by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month		2b. HOUR	
Herbert		C.		Hann		Nov.		15, 1968		5:20A M	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		Caucasian		3/23/98				70 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
New York		USA				Prince George's Md					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince Geo. Gen'l Hospital				Retired Mail Carrier		U S Government			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY (Y/N)		13e. STREET AND NUMBER			
Maryland		Prince George's		Bowie		YES <input type="checkbox"/> NO <input type="checkbox"/>		6610 Alexis Drive			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Charles Hann				Christina Crocoll							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>				579 46 4385		Frieda E Hann		Bowie, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac metastatic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of lung</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
										11-10-68	
										10-20-68	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) <u>(this box)</u> attended the deceased from <u>Sept. 30, 1968</u> to <u>Nov. 15, 1968</u> , that (I) <u>was</u> last saw the deceased alive on <u>Nov. 15, 1968</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) <u>not</u> view the body after death.											
22b. SIGNATURE <u>George Hageage</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/>		22c. DATE SIGNED <u>11-15-68</u>			
22d. PHYSICIAN'S NAME (Type) George Hageage, M. D.						22e. ADDRESS 3717 38th Ave., Cottage City, Md. 20722					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Nov 18, 1968		Cedar Hill Cemetery		Suitland Pro Geo				Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR DATE NOV 19 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

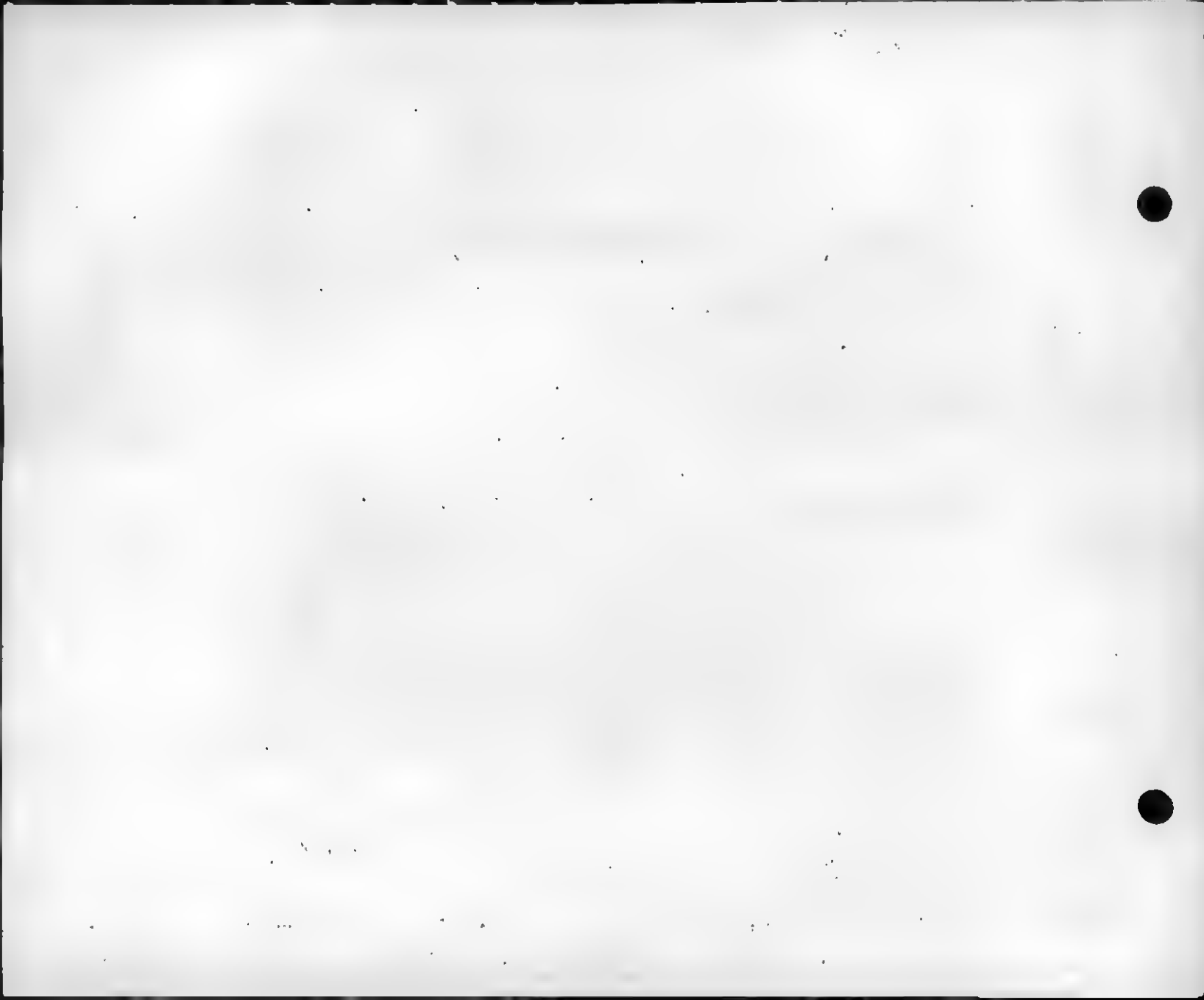
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers, ages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16345

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16350

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Ola Violet Harmon					Month	Day	Year	7 ⁵⁵ AM
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR	
Female	Caucasian		9-13-1896		72 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland	U.S.A.				Prince Georges Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Greenbelt, Md		Greenbelt Convalescent Center		Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Pr. Georges		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5620 - 31st Ave
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
First Middle Last			First Middle Last					
Luther Watson			Mary Ball					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
		577-30-8375		Nursing Home Records		Leinhardt 2nd		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Mitotic Carcinoma</u>								several months
1538 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) <u>Carcinoma of Colon</u>								4+ years
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. co. examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , to <u>11-15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE						22c. DATE SIGNED		
<u>Donald C. Edgren</u> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type) <u>DONALD C. EDGREN</u>						22e. ADDRESS <u>Hyattsville, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Nov 19, 1968		Cedar Hill Cemetery		Suitland Pro Geo Md.		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
F. Gasch's Sons				Hyattsville, Md.		DATE NOV 19 1968		<u>M. J. Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16346

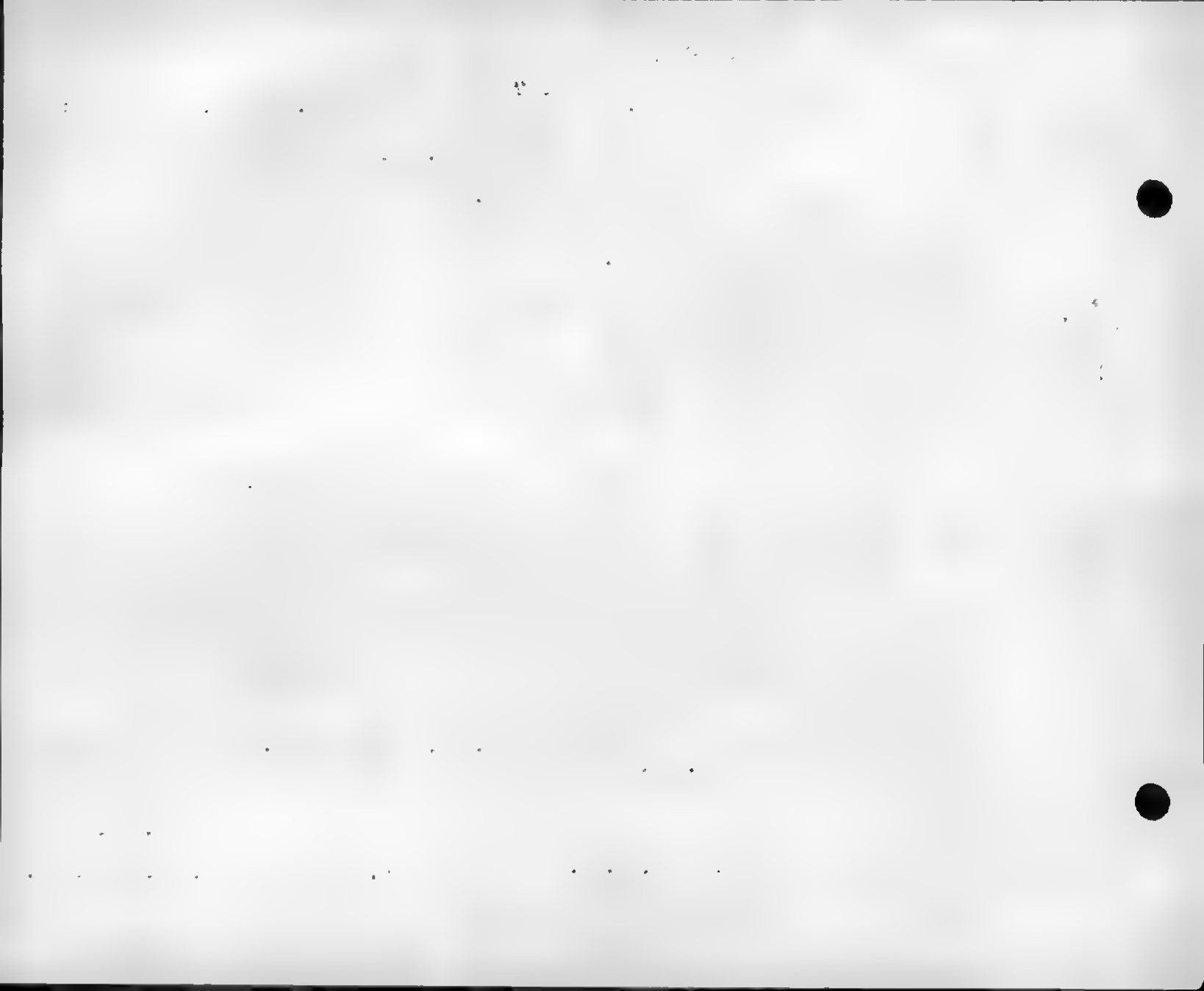
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16346

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Sherman E. Harper			2a DATE OF DEATH Nov. Month 21 , Day 1968 Year			2b HOUR 1:45 PM					
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH Jan. 27, 1910		6. AGE (In years last birthday) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE (State or foreign country) W Va		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md					
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital			2a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) bricklayer			12b KIND OF BUSINESS OR INDUSTRY contractor		
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland			13b. CITY OR TOWN Annapolis		13c INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER Annapolis Junction				
14 FATHER'S NAME First Middle Last unknown			15. MOTHER'S MAIDEN NAME First Middle Last unknown								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) yes			16b. SOCIAL SECURITY NO		17 INFORMANT Christine Kelly Address 554 Greenway Ave Baltimore Md						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC AND RESPIRATORY ARREST 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Acute Anteroseptal myocardial INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic heart disease. (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b TIME OF INJURY HOUR AM Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that the (this hospital) attended the deceased from Nov. 14, 1968 to Nov. 21, 1968 , that he (we) last saw the deceased alive on Nov. 21, 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above the (we) (did) not view the body after death.											
22b SIGNATURE Luis Bentolila						DEGREE M. D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED Nov. 21, 1968	
22d PHYSICIAN'S NAME (Type) Luis Bentolila, M. D.						22e. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 11-23-68		23c NAME OF CEMETERY OR CREMATORY Balt Natl		23d LOCATION (City or Town) (County) (State) Baltimore Md.				
24. FUNERAL DIRECTOR Donaldson J.H. Samuel						ADDRESS		25a. REC'D BY REGISTRAR NOV 29 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge	

VR A15
45M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

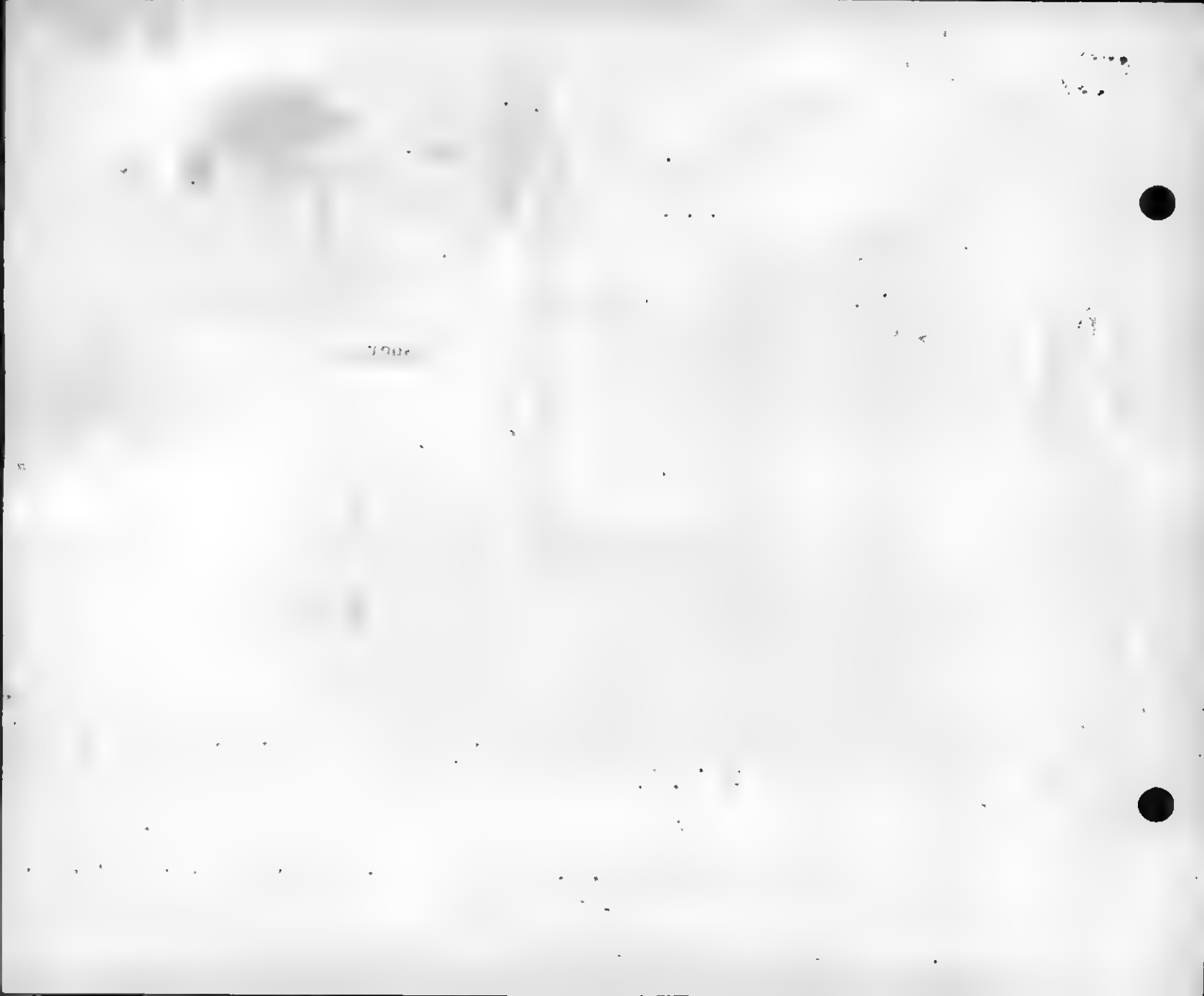
VR A15
304A REV 1-68

16347

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16361

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Baby Boy		Harrellson			Nov. Month 17 Day 68 Year		6:30AM	
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Male	Cauc.		11-17-68		YRS	2		50
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland	U.S.A.			Prince Georges		Md.		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince Georges Gen. Hosp.						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Md.		Prince Georges	Landover		1950 Brightseat Road			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last					
Jack Parker Harrellson			Nance Fisher					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Punctate Infarct</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) <i>Probable a Spleen Tumor</i>								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that he (this hospital) attended the deceased from Nov. 17, 1968, to Nov. 17, 1968, that he (we) last saw the deceased alive on Nov. 17, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did not) view the body after death.								
22b. SIGNATURE <i>Bernardo Alvarado, M.D.</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED Nov. 22, 1968		
22d. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M. D.				22e. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11/30/68		23c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital		23d. LOCAT ON (City or Town) (County) (State) Cheverly, Maryland		
24 FUNERAL DIRECTOR ADDRESS William A. Parker, Assoc. Administrator				25a. REC'D. BY REGISTRAR DATE DEC 3 1968		25b. REGISTRAR'S SIGNATURE <i>John A. Yager</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 11-68
30M REV 11-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH	
Joseph		V.		Harris		11		2b HOUR 1:35 P	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS	
Male		Negro		7/14/1902		66		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9a COUNTY OF DEATH		9b M.D.	
Indiana		U.S.A.				Prince Georges			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tol give street address)		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Glenn Dale		Glenn Dale Hospital		Mover					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
				Wash., D.C.				5000 C St., S. E.	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME First Middle Last	
Joseph		--		Harris				Mattie -- Clayton	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
no		unknown		D. C. General Hospital & previous Glenn/		Dale Hosp. records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Bronchopleural fistula, left.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3yr., 1mo.
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING ETC.		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from 11/24/1968, to 11/27/1968, that (we) last saw the deceased alive on 11/27/1968, and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c -DATE SIGNED			
Moe Weiss						11/27/68			
22d PHYSICIAN'S NAME (Type)		22e ADDRESS							
Moe Weiss, M. D.		Glenn Dale Hospital Glenn Dale, Maryland							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCAT ON (City or Town)		(County) (State)	
Burial		12-3-68		HARMONY Cem		LANDOVER, Md			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Frazier F. H. Gophers		381 R.I. Ave.		DEC 5 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

16349

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16349

1. DECEASED NAME (Type or print) James W Harrison Jr.			2a. DATE OF DEATH Month Nov Day 4 Year 1968			2b. HOUR 7:30 AM	
3. SEX male		4. RACE white		5. DATE OF BIRTH May 31, 1910-		6. AGE (in years last birthday) 58 YRS.	
7a. BIRTHPLACE (State or foreign country) Indiana		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pro Geo Md.	
10. CITY OR TOWN OF DEATH Bladensburg,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4235 58th ave		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Oil co	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md		13b. COUNTY Pro Geo		13c. CITY OR TOWN Bladensburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 4235 58th ave.							
14. FATHER'S NAME First Middle Last James W Harrison				15. MOTHER'S MAIDEN NAME First Middle Last Bertha M Buckland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? yes (If yes give war or dates of service) W W II		16b. SOCIAL SECURITY NO 579 01 4629		17. INFORMANT Address Helen E Harrison Bladensburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory, Bacterial DUE TO, OR AS A CONSEQUENCE OF (b) Angiographic fat Sclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from send , 19 67 , to Nov , 19 68 , that (I) (we) last saw the deceased alive on Nov 3 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE Wm C Weintraub				22c. DATE SIGNED Nov 6 1968		22d. ADDRESS Greenbelt, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 6, 1968		23c. NAME OF CEMETERY OR INTERMENT Washington National		23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE NOV 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV

16350												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												16364																							
1 DECEASED-NAME (Type or print) First Middle Last												2a. DATE OF DEATH Month Day Year												2b. HOUR																							
EDWARD M. HINES												11-21-68												1:53 PM																							
3 SEX				4 RACE				5 DATE OF BIRTH				6 AGE (In years lost birthday)				7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH																			
Male				White				2-4-91				77 YRS				Wash. DC				U.S.A				Prince George Md.																							
10. CITY OR TOWN OF DEATH								11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)								12b. KIND OF BUSINESS OR INDUSTRY																							
Clinton								Pineview Garden								Sheet metal work																															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE								13b. COUNTY								13c. CITY OR TOWN								13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								13e. STREET AND NUMBER															
Md.								Pe. George								Silver Hill								YES								2543 Iverson St.															
14 FATHER'S NAME First Middle Last												15. MOTHER'S MAIDEN NAME First Middle Last																																			
Edward Michael Hines												Emma Martha Adams																																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)												16b. SOCIAL SECURITY NO												17 INFORMANT Address																							
Yes no, or unknown												578-07-2128-A												Mrs. Ruth Webster																							
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												Cardiac failure / Collapse																																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												(b) Hypertension & myocardial infarction																																			
DUE TO, OR AS A CONSEQUENCE OF												(c) Hypertension																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																															
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED												20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>												20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)												21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19												21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>												21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)												21f. LOCATION Street or R.F.D. No City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from 6-7, 1968, to 11-21, 1968, that (I) (we) last saw the deceased alive on 11-21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																															
22b. SIGNATURE												22c. DATE SIGNED												22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS											
Alfred R. Appling												11-21-1968												ALFRED R. APPLING												Clinton, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)												23b. DATE												23c. NAME OF CEMETERY OR CREMATORY												23d. LOCATION (City or Town) (County) (State)											
Burial												11/23/1968												Ford Lincoln												Prince Georges Md											
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR												25b. REGISTRAR'S SIGNATURE																							
Maltony												131-11th H. SE.												DATE NOV 25 1968												John Charles Judge											

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH Month Day Year		
Mattie			L.		Hofmann		Nov.		Month 13, Day 1968 Year		
3. SEX			4. RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDECEASED 24 HRS	
Female			White		25 July 1896			72 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
North Carolina			U S A			Prince George's			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Geo. Gen'l Hospital			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Prince George's Seat Pleasant						13e. STREET AND NUMBER		
									6900 George Palmer Highway		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		
First Middle Last			First Middle Last			Yes, no, or unknown					
-----			Croan			unknown					
17. INFORMANT			Address			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
William Hofmann			6900 Geo. Palmer Hwy.			PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure.					
						(b) Bilateral pulmonary edema and congestion, severe.					
						(c) Arteriosclerotic coronary artery disease, severe.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			Diabetes Mellitus (clinical)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that xx (this hospital) attended the deceased from Nov. 12, 1968, to Nov. 13, 1968, that xx (we) last saw the deceased alive on Nov. 13, 1968, and that in xx (our) opinion death occurred on the date and hour and from the causes stated above. xx (we) (did) (not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		
Fidel J. Quintana			Nov. 13, 1968			FIDEL J. QUINTANA			Prince Geo. Gen'l Hospital, Cheverly, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			11-16-68			Washington National Cem.			Suitland Ir. Geo. Md.		
24. FUNERAL DIRECTOR			25a. NOV 20 1968			25b. REGISTRAR'S SIGNATURE					
Wilhelm Funeral Home			4308 Suitland Rd. S. L.			DATE			Charles Judge		



FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 16352 MARYLAND STATE DEPARTMENT OF HEALTH 16352 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>											
1. DECEASED-NAME (Type or print) Russell				First Middle Last E. Hudson				2a. DATE OF DEATH Month Day Year 11 18 1968			2b. HOUR 10 P M
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 8/21/1918			6. AGE (In years last birthday) 50		IF UNDER 1 YEAR MONTHS DAYS YRS		IF UNDER 24 HRS HOURS MIN MIN
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md					
10. CITY OR TOWN OF DEATH Glenn Dale		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Glenn Dale Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) unknown - retired			12b. KIND OF BUSINESS OR INDUSTRY unknown			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD				13b. CITY OR TOWN Washing., D.C.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3546 11th St., N. W.			
14. FATHER'S NAME First Middle Last Edmond -- Hudson				15. MOTHER'S MAIDEN NAME First Middle Last Mary -- Taylor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO 225-14-0971		17. INFORMANT Address Decedent							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction 41-- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 42-- (b) Hypertensive cardiovascular and DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease years											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pulmonary tuberculosis, moderately advanced											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/11/ , 19 68 , to 11/18 , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/18/ 19 68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.											
22b. SIGNATURE Moe Weiss				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED 11/18/1968			
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland							
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 11/23/68		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park			23d. LOCATION (City or Town) (County) (State) P.C.C. Landover Md.				
24. FUNERAL DIRECTOR 2001-14-11-11-11-11		ADDRESS 3321 14th St.		25a. REC'D BY REGISTRAR NOV 2 1968		25b. REGISTRAR'S SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last Charles S. Huggins			2a DATE OF DEATH Month Day Year November 14, 1968		2b HOUR 1:17 P.M.	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 12/27/1906		6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md			
10 CITY OR TOWN OF DEATH Glenn Dale			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Painter		12b KIND OF BUSINESS OR INDUSTRY --	
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE D.C.			13c CITY OR TOWN Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER No fixed address		
14. FATHER'S NAME First Middle Last Grant Huggins			15 MOTHER'S MAIDEN NAME First Middle Last Nora Hester						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes			16b. SOCIAL SECURITY NO 579-03-2392		17. INFORMANT Address Decedent				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 472X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Acute cor pulmonale DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary emphysema and fibrosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 5 days years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fracture of left hip.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/20/ , 19 66 , to 11/14/ , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/14/ , 19 68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.									
22b. SIGNATURE <i>Moe Weiss</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 11/14/1968			
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11/20/68		23c. NAME OF BURIAL OR CREMATION ANATOMICAL BOARD		23d. LOCATION (City or Town) (County) (State) Washington Prince Georges Md			
24. FUNERAL DIRECTOR <i>Carl F. Oufelt</i>				ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 22 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

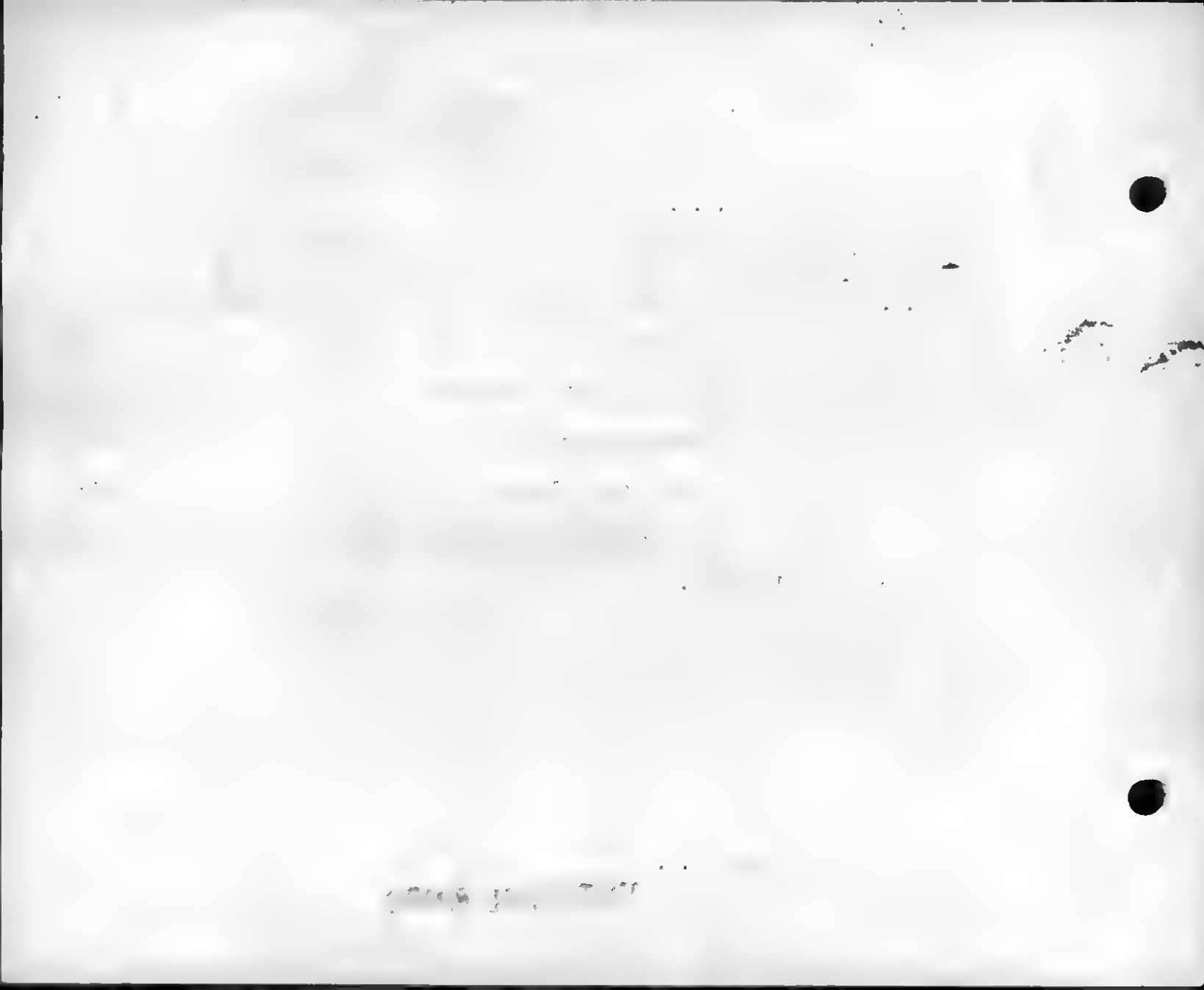
2

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16358

16361



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 10. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

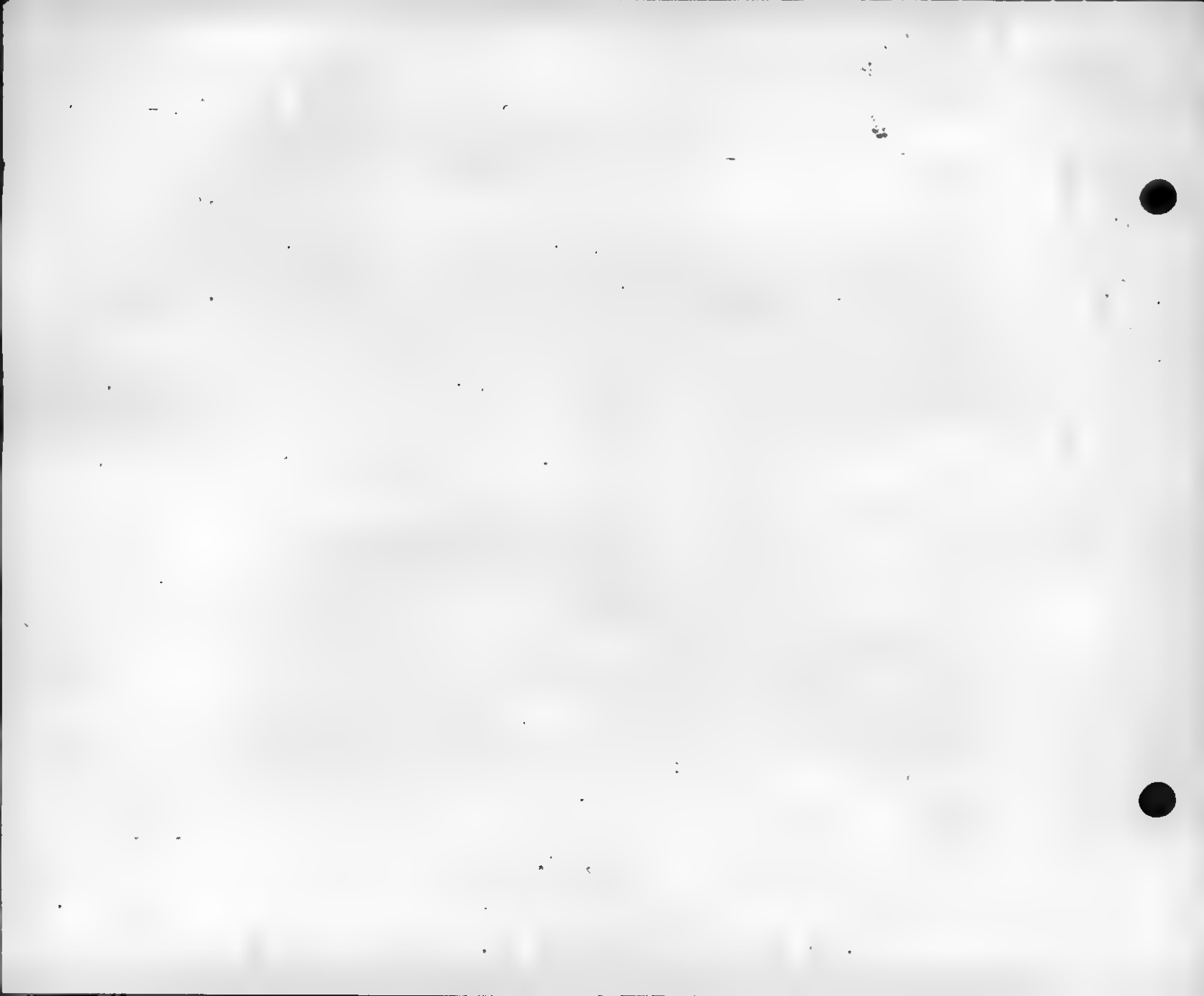
16354

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16364

1. DECEASED NAME (Type or Print)		First		M. date		Last		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 11-14-68 19 8:15 PM				2b. HOUR	
George		Jackson											
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	8-22-1899		69 YRS		MONTHS DAYS		HOURS MIN.		11 14 68 19 8:18 PM			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
New Jersey		U S A				Prince George's						Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY							
Cheverly		Prince George Hospital		Retired		Grocery							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY L.M.T.S?		13e. STREET AND NUMBER					
Maryland		Prince George's		Brentwood		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4403 38th. Street					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S M.A.DEN NAME		First		M. adie Last	
Unknown								Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS							
no		265 05 1042		Willard Jackson		Riverdale, Md.							
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4200</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHOLE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <u>11-15-68</u>					
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.				ASS STANT MED. CAL. EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial				Nov 18, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
F. Gasch's Sons				Hyattsville, Md.				NOV 18 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

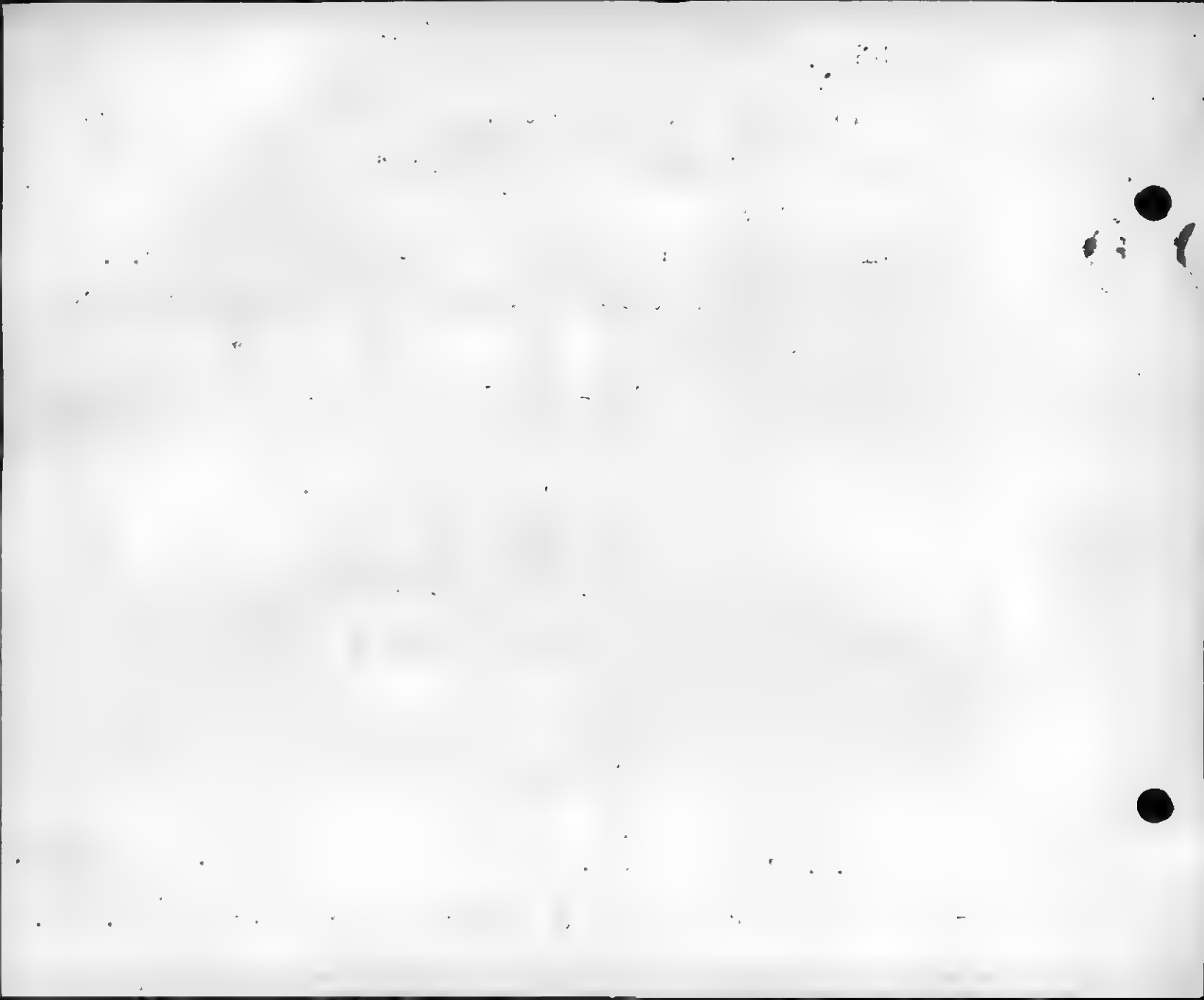
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30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16739

16355

1. DECEASED-NAME (Type or print) First Middle Last <u>Albert J. Jacobson</u>			2a. DATE OF DEATH Month Day Year <u>11 28 68</u>			2b. HOUR M <u>11</u>									
3 SEX <u>male</u>		4 RACE <u>white</u>		5. DATE OF BIRTH <u>8/16/35</u>		6. AGE (in years last birthday) <u>33</u> YRS.		7. FUNERAL 1 YEAR MONTHS DAYS <u>33</u>		8. IF UNDER 24 HRS HOURS MIN. <u>11</u>					
7a. BIRTHPLACE (State or foreign country) <u>Sweden</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Prince Georges</u> Md									
10. CITY OR TOWN OF DEATH <u>Riverdale</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Leland Memorial</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Painter</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Transit</u>						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Maryland</u>			13b. COUNTY <u>Prince Georges</u>			13c. CITY OR TOWN <u>Mt. Rainier</u>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <u>3307 Chauncey Place</u>			
14. FATHER'S NAME First Middle Last <u>Jacob Jacobson</u>				15. MOTHER'S MAIDEN NAME First Middle Last <u>Maria Nielson</u>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO <u>573-10-8169</u>				17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>gangrene foot & amputation of leg</u>															
19a. DATE OF OPERATION <u>11-24-68</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>above</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>11-28</u> , 19 <u>68</u> , to <u>11-28</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-28</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>R.F. Wilkinson</u>								DEGREE <u>M.D.</u>		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <u>R.F. Wilkinson, M. D.</u>								22e. ADDRESS <u>4400 Queensbury Rd. Riverdale, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>12/2/68</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>						
24. FUNERAL DIRECTOR <u>The S.H. Hines Co</u>						ADDRESS <u>2901-14th St. N.W. Washington D.C.</u>			25a. REC'D BY REGISTRAR <u>DEC 2 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



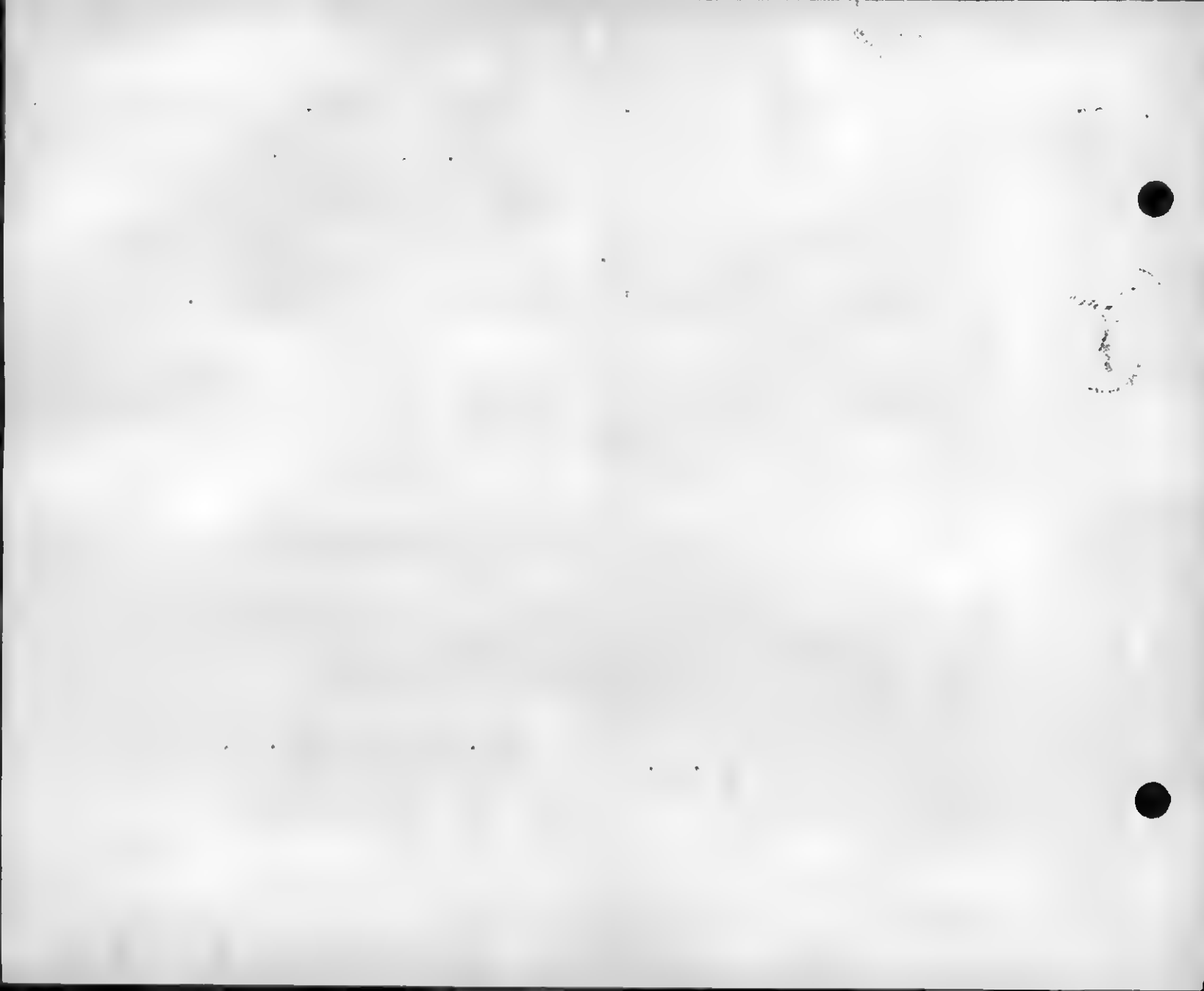
16356

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> , Year <u>1968</u>		2b. HOUR <u>1:15 PM</u>	
Mary		E.		Jeffries				
3 SEX Female	4 RACE Caucasian		5. DATE OF BIRTH Feb. 13, 1891		6. AGE (In years last birthday) 77 YRS	IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN _____
7a. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5706 Ager Rd.
14. FATHER'S NAME First Unknown		Middle HURLEY		Last Unknown		15. MOTHER'S MAIDEN NAME First Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213561473		17. INFORMANT CHARLES D. JEFFRIES, 4013 WARNER AV HYATTSVILLE, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary arrest 4101 DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) atherosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____				
22a. I certify that xx (this hospital) attended the deceased from <u>Nov. 24, 1968</u> , to <u>Nov. 24, 1968</u> , that (I) xxx last saw the deceased alive on <u>Nov. 24, 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, xx (we) (did) not view the body after death.								
22b. SIGNATURE <i>Fidel J. Quintana</i>		DEGREE FIDEL J. QUINTANA		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 11-25-68		
22d. PHYSICIAN'S NAME (Type)		FIDEL J. QUINTANA		22e. ADDRESS 8715 1st Ave. S. S. ANN				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11-27-1968		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d. LOCATION (City or Town) (County) (State) COLMAR MANOR MARYLAND		
24. FUNERAL DIRECTOR W. W. CHAMBERS		ADDRESS RIVERDALE, MD		25a. RECEIVED BY NOV 29 1968		RECEIVED BY SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

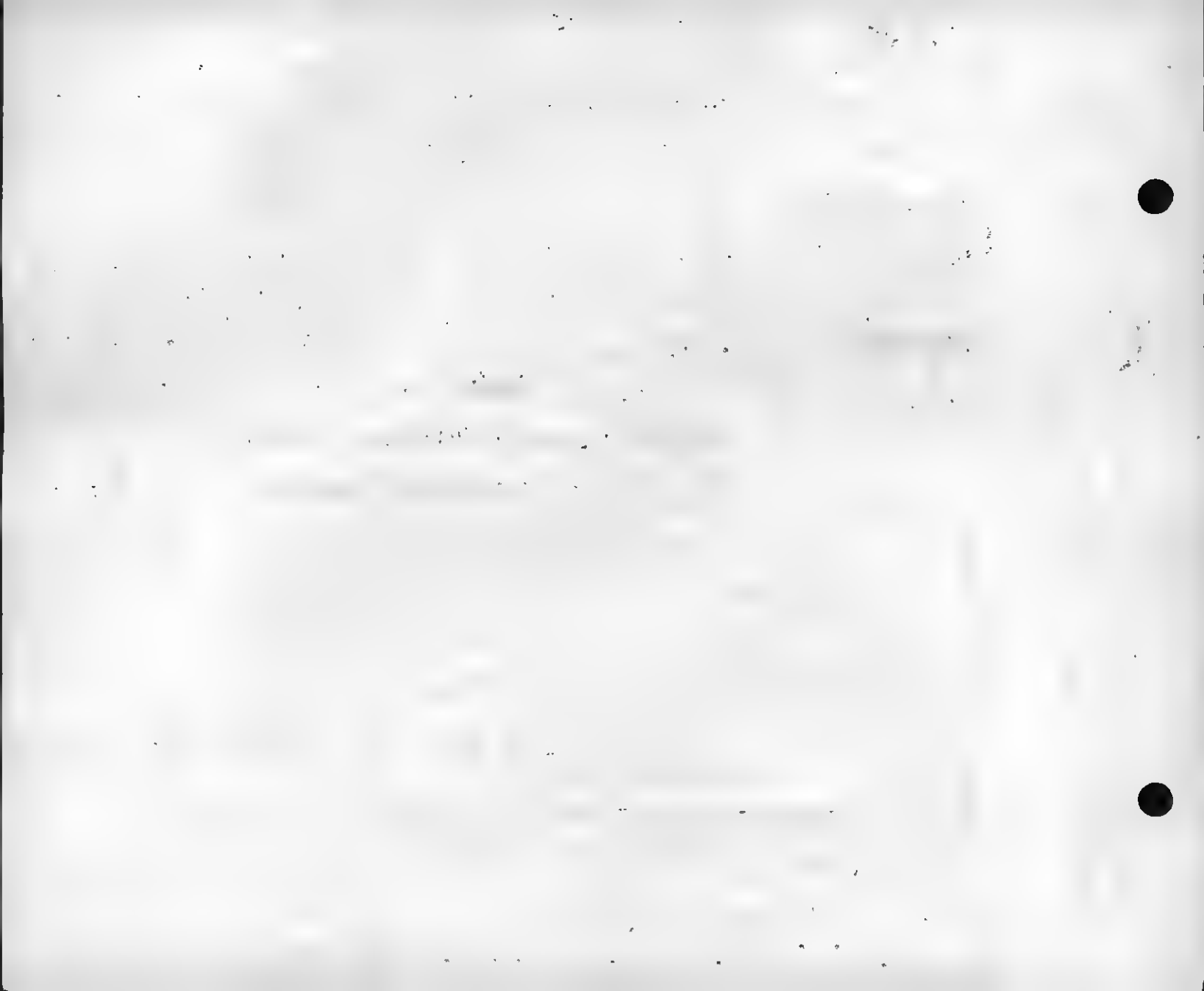
CERTIFICATE OF DEATH

16357

16371

1. DECEASED NAME (Type or print) Curtis Chester JOHNSON			2a. DATE OF DEATH 11 Month 29 Day 68 Year		2b. HOUR 10 P M
3. SEX male	4. RACE white	5. DATE OF BIRTH JAN 14, 1886		6. AGE (In years last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Minnesota USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges Md		
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6911 Nashville Rd	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Fireman	12b. KIND OF BUSINESS OR INDUSTRY Fire Dept		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Md	13b. COUNTY Prince Georges	13c. CITY OR TOWN Lanham	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 6911 Nashville Rd	
14. FATHER'S NAME First Jerse Middle Johnson Last Johnson		15. MOTHER'S MAIDEN NAME First Julia Middle Amenda Last Steirwalt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO 514-46-3110	17. INFORMANT Sadie Johnson (wife) Address 6911 Nashville Rd Lanham Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute renal failure and uremia DUE TO, OR AS A CONSEQUENCE OF (b) Prostatic carcinoma, invasive DUE TO, OR AS A CONSEQUENCE OF (c) 11 years					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 1111					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from July , 19 64 , to Nov , 19 68 , that (I) (we) last saw the deceased alive on Nov 29 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE TRA Sanchez MD DEGREE <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 11-29-68	
22d. PHYSICIAN'S NAME (Type) Riccardo U. FRANCHI			22e. ADDRESS 7729 Finns Lane, Lanham Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/4/68	23c. NAME OF CEMETERY OR CREMATORY Reading Cemetery	23d. LOCATION (City or Town) (County) (State) Reading Kansas		
24. FUNERAL DIRECTOR M. H. Dwyall M.D. Address Warner E. Pumphrey Inc. 8434 Ga. Ave. S.S., Md.			25a. REC'D BY REGISTRAR DEC 5 1968	25b. REGISTRAR'S SIGNATURE W. C. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16358

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Margaret Johnson			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 11 Day 25 Year 68 12b HOUR 3:15am		
3 SEX Female	4 RACE Negro	5. DATE OF BIRTH 7-27-1922	6 AGE (in years last birthday) 46 YRS	7 UNDER 1 YEAR MONTHS 11 DAYS 25	IF UNDER 24 HRS HOURS 3 MIN 15
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Maid
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admiss on) STATE Maryland 13b. COUNTY Prince George's			13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME First Richard Middle Thomas Last Thomas			15. MOTHER'S MAIDEN NAME First Maggie Middle Matthews Last Matthews		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO -		17 INFORMANT William Thomas ADDRESS 11907 Ellington Drive
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple gun shot wounds of chest DUE TO, OR AS A CONSEQUENCE OF (b) 65 X DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 1:00am 11-25-1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Shot during altercation	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No same as # 13 City or Town Beltsville County Prince George's State Md	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 11-25-68	
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL CREMATION REMOVAL (Specify) 11-30-68		23b. DATE 11-30-68		23c. NAME OF CEMETERY OR CREMATORY Queens Chapel	
24. FUNERAL DIRECTOR H.S. Washington & Son 4925 Denae Avenue		ADDRESS H.S. Washington & Son 4925 Denae Avenue		25a. REC'D BY REGISTRAR DEC 2 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. LOCATION (City or Town) Mount Airy (County) Md (State) Md			

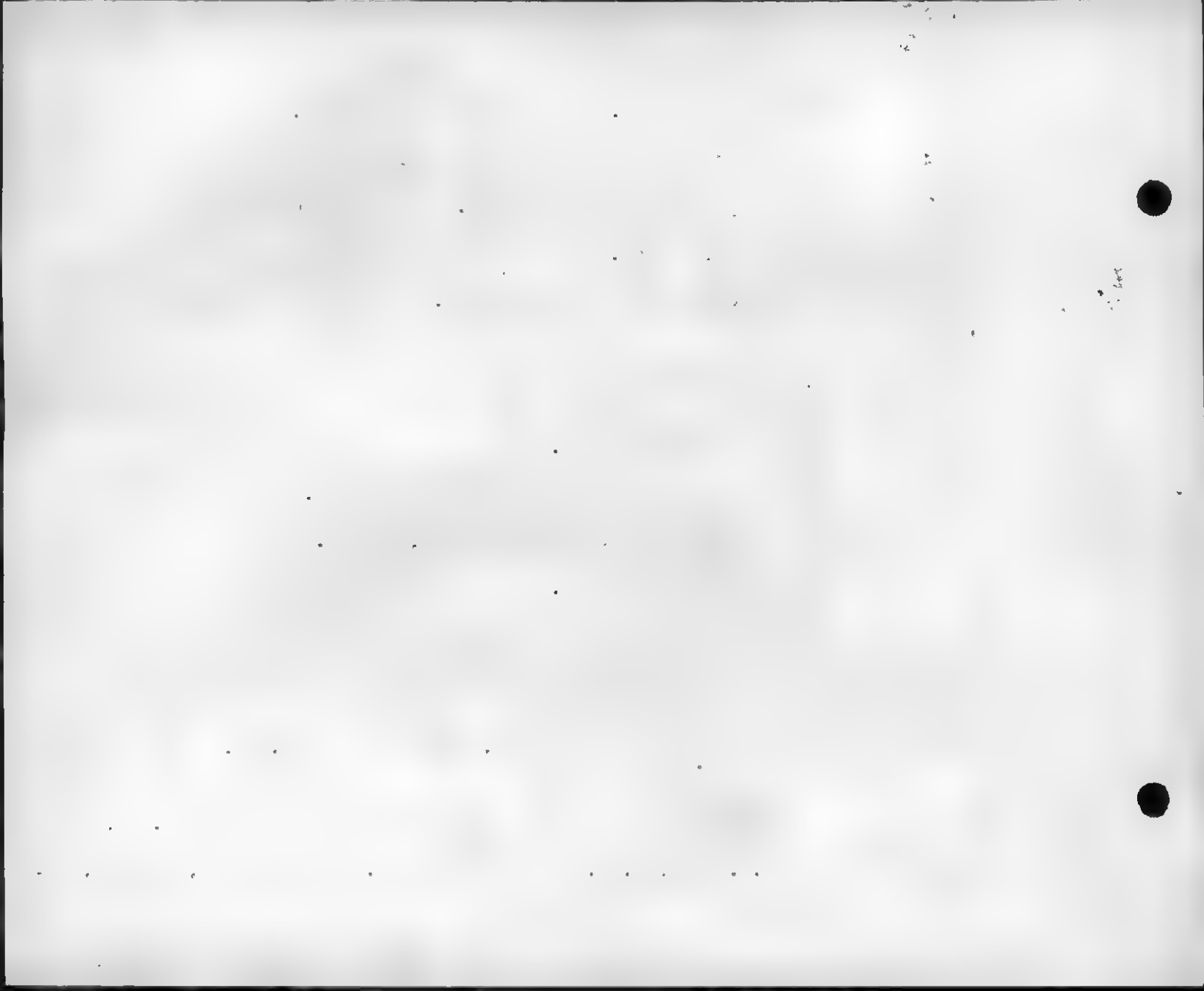
1951

1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~insert~~ ^{insert} carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16359		CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Esther M. Jones						Nov. 26, 1968			1:50AM
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Negroid		May 20, 1922		46 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>		9. COUNTY OF DEATH			
DC		U.S.A.				Prince George's			Md
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince Geo. Gen'l Hospital			Teacher		Wash. D.C.	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY R.M. 157 YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Prince George's		Fairmont Hgt.				6108 K Street
14. FATHER'S NAME First Middle Last			15. MOTHER'S M.A.D.E.N. NAME First Middle Last						
Byron McNeil			Sylvia Morton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give way or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			None		Johnny B Jones 2643 Bowen Rd SE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u> 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Hypertensive Cardiovascular disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Arteriosclerosis, severe.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 773X <u>Cerebral edema.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. ALTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that xx (this hospital) attended the deceased from Nov. 24, 1968, to Nov. 26, 1968, that xx (we) last saw the deceased alive on Nov. 26, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. xx (we) (did) not view the body after death.									
22b. SIGNATURE <i>[Signature]</i>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED Nov. 26, 1968		
22d. PHYSICIAN'S NAME (Type) S.V. Nair, M. D.					22e. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
B		11-29-68		Harmony		Highland Park Md			
24. FUNERAL DIRECTOR H. S. Worthington & Son 4933					25a. REC'D BY REGISTRAR DEC 2 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

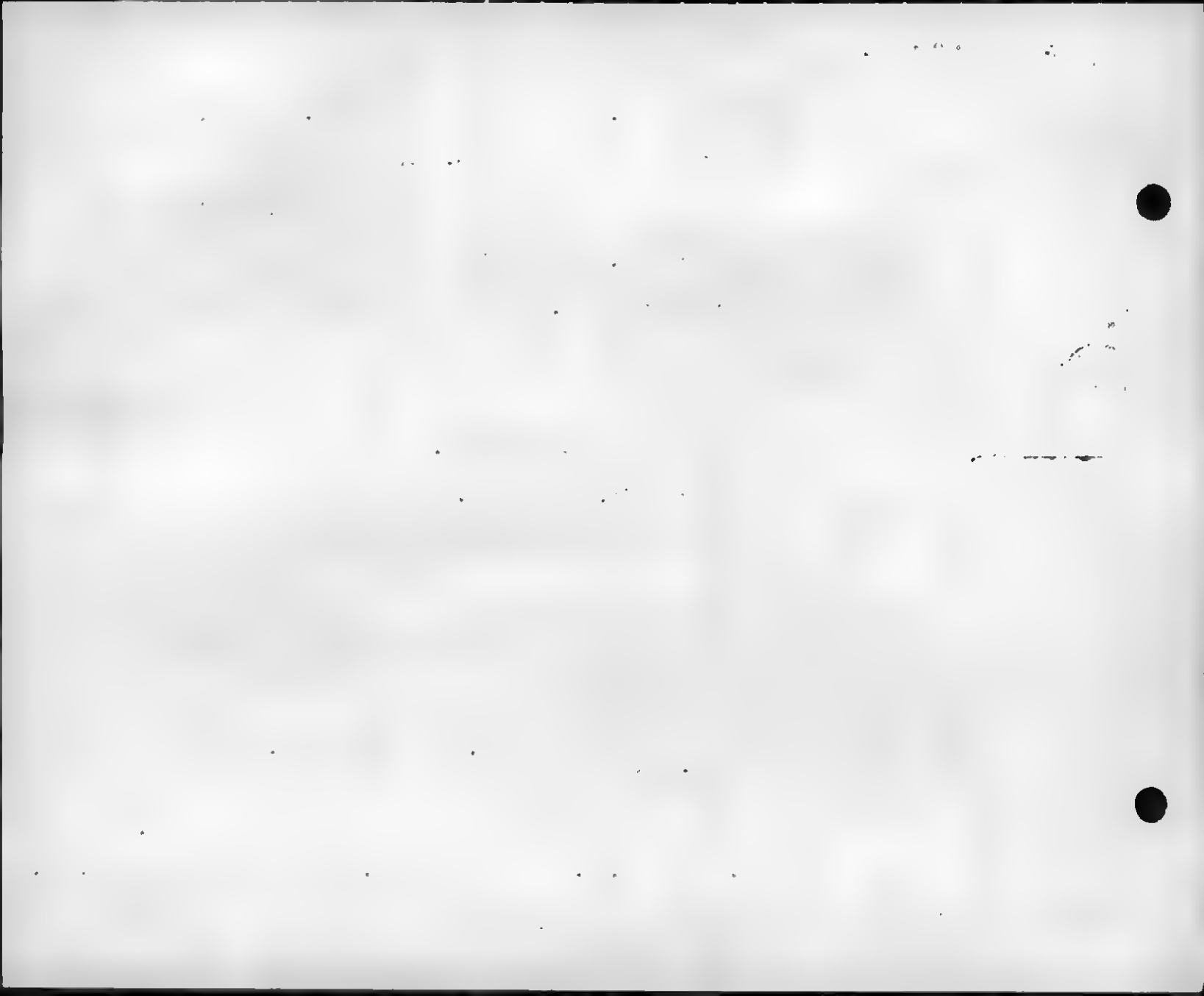
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16360

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10074

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1968</u>			2b. HOUR <u>1:10AM</u>		
3. SEX <u>Female</u>			4. RACE <u>Negroid</u>		5. DATE OF BIRTH <u>Jan. 11, 1903</u>			6. AGE (In years last birthday) <u>65</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Prince George's</u>			Md		
10. CITY OR TOWN OF DEATH <u>Cheverly</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Prince Geo. Gen'l Hospital</u>			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <u>Domestic</u>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE <u>Maryland</u>			13b. COUNTY <u>Prince George's</u>		13c. CITY OR TOWN <u>St. Pleasant</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>7281 Kolb Street</u>		
14. FATHER'S NAME First <u>William</u> Middle <u>Jones</u> Last			15. MOTHER'S MAIDEN NAME First <u>Mary</u> Middle <u>Brown</u> Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Sister</u> <u>Mrs. Margaret Smith-7281 Kolb St</u> Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Diffused Carcinomatosis.</u> <u>1942</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pneumonia, right lung.</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from <u>Nov. 4, 1968</u> to <u>Nov. 25, 1968</u> , that (X) (we) last saw the deceased alive on <u>Nov. 25, 1968</u> , and that (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (not) view the body after death.											
22b. SIGNATURE <u>Arnold G. Brody, M.D.</u>						22c. DATE SIGNED <u>Nov. 25, 1968</u>		22d. PHYSICIAN'S NAME (Type) <u>Arnold G. Brody, M.D.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>11/29/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>		24. FUNERAL DIRECTOR <u>Stewart Funeral Home-4001 Benning Road</u>			
25a. REC'D BY REGISTRAR <u>Nov 29 1968</u>						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-768

16361										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10570									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
RICHARD P JONES										Month NOV Day 13 Year 68										2350									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
MALE			CAUCASIAN			18 JUN 65			3 YRS.			MONTHS			DAYS														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
TEXAS			UNITED STATES						PRINCE GEORGE						Md														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY																				
CAMP SPRINGS, MD			MALCOLM GROW USAF HOSP			DEPENDENT						NONE																	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
MARYLAND			PRINCE GEORGE			CAMP SPRINGS						4254-1 DOGWOOD LANE																	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last																										
WILLIAM W JONES			EMMA L. L TOBIAS																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address																				
NO			NONE			WILLIAM W JONES			4254-1 DOGWOOD LANE																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA										1 WEEK																			
34-30 DUE TO, OR AS A CONSEQUENCE OF (b) SPASTIC CEREBRAL PALSY WITH MENTAL RETARDATION										3 YEARS																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) & SEIZURE DISORDER.																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
6 NOV 68					BALANITIS- CIRCUMCISION					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (this hospital) attended the deceased from 10 NOV, 1968, to 13 NOV, 1968, that (I) (we) last saw the deceased alive on 13 NOV, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										22c. DATE SIGNED																			
Kenneth A Bradford, M.D. DEGREE										13 NOV 68																			
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
KENNETH A BRADFORD, CAPT, USAF										MALCOLM GROW USAF HOSP, ANDREWS AFB MD																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					11-18-68					Arlington National					Arlington, Virginia														
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
W. W. Chambers Co. 517-11, St. S-E.										DATE NOV 18 1968										James J. Jones									



CERTIFICATE OF DEATH

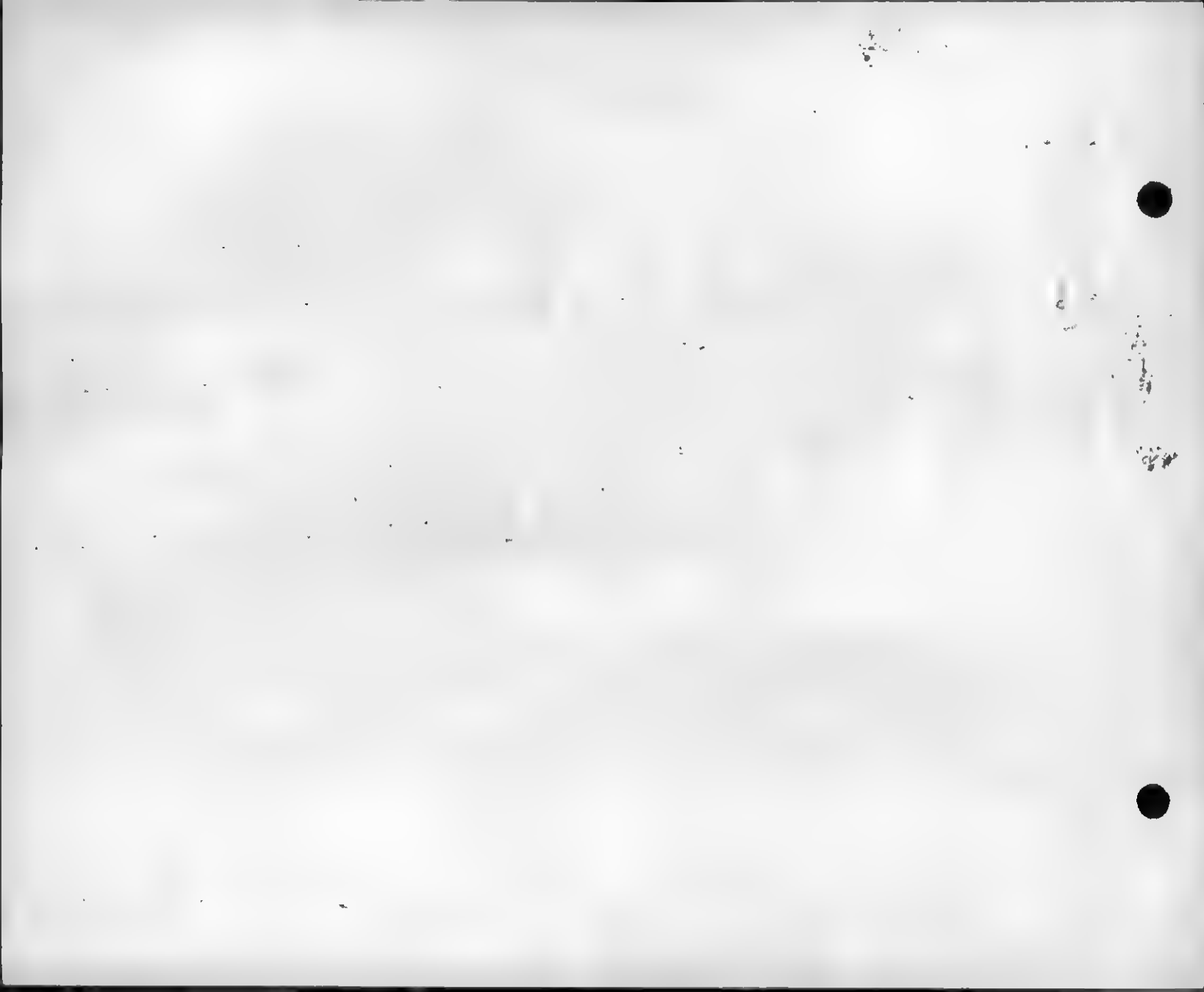
16362

10370

1. DECEASED-NAME (Type or print) William Richard Jones			2a. DATE OF DEATH Month Nov Day 26 Year 1968			2b. HOUR 10:47 PM	
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH 11/05/93		6. AGE (In years last birthday) 75 YRS.	
7a BIRTHPLACE (State or foreign country) PENNA		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md	
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. General		12a USUAL OCCUPATION (Kind of work done during most of work night, even if retired) BOOK BINDER		12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Prince George's		13c CITY OR TOWN Riverdale		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First William R. Middle Jones Last Jones		15 MOTHER'S MAIDEN NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b SOCIAL SECURITY NO. 220-40-5992		17 INFORMANT ROBERT C. JONES 8518 COWINGHAM RD BERWYN HTS, MARYLAND			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Arteriosclerotic aneurysm of the Abdominal Aorta with massive right Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Retro-Peritoneal Hemorrhage, 2. Arteriosclerotic Heart Disease, severe with extensive (c) Myocardial Fibrosis, Generalized Arteriosclerosis, severe.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 451X							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR AM Month Day Year 19 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory, office building, etc.)		21f. LOCATION Street or RFD. No. City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from 11-26 , 19 68 , to 11-26 , 19 68 , that (I) (we) lost saw the deceased alive on 11-26 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE R.D. Baner, M.D.		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 11-26-68	
22d. PHYSICIAN'S NAME (Type) R.D. Baner, M.D.		22e ADDRESS 2513 Buck Lodge Rd. Annapolis, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 11-30-1968		23c NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d LOCATION (City or Town) (County) (State) SOITLAND, MARYLAND	
24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.				25a REC'D BY REGISTRAR DEC 5 1968		25b REGISTRAR'S SIGNATURE W. Chambers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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24. FUNERAL DIRECTOR

J. L. Escudé

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

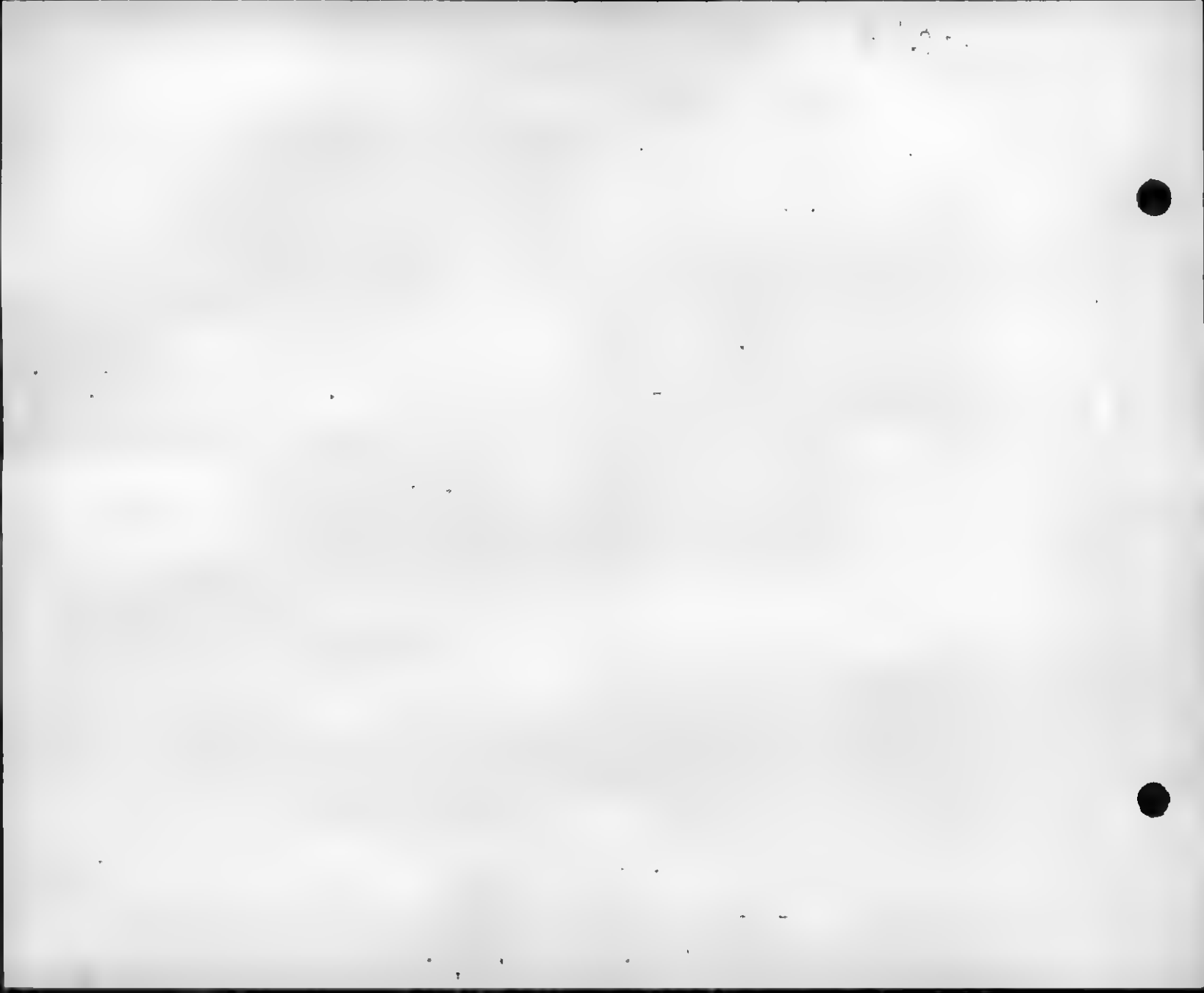
Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1637:

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		Month		Day		Year		2b HOUR			
Daniel		G.		Joseph				Nov. 26, 1968								12:30 A.			
3 SEX		4 RACE		5 DATE OF BIRTH				6 AGE (in years last birthday)		7 FUND YEAR		8 IF UNDER 24 HRS							
Male		Caucasian		April 15, 1906				62 YRS		MONTHS		DAYS		HOURS		MIN			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH													
Washington D.C.		USA				Prince George's Md													
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY													
Cheverly		Prince Geo. General Hosp.																	
3a USUAL RESIDENCE (Where deceased admission)		11b COUNTY		13c CITY OR TOWN		13d INSIDE CITY (M-157 YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER											
Maryland		Prince George's		Seat Pleasant				300 Addison Road											
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S M A DEN NAME		First		Middle		Last					
Daniel		G.		Joseph		Sr.		Mary						Mussante					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		Address													
no		577-05-4260		Mrs. Helen P. Joseph		Ridge Rd. Arlington Va													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Cardiac Arrest. Acute Myocardial Infarction																			
DUE TO, OR AS A CONSEQUENCE OF																			
(b) Arteriosclerotic Heart Disease.																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
201																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX													
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)				21f LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from Nov. 18, 1968, to Nov. 26, 1968, that (I) (we) last saw the deceased alive on Nov. 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																			
22b. SIGNATURE																22c. DATE SIGNED			
Thomas Hernandez, M.D.																11/27/68			
22d PHYSICIAN'S NAME (Type)																22e ADDRESS			
Thomas Hernandez, M.D.																3308 Dodge Park Rd., Landover, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)											
Burial		11-29-68		Cedar Hill Cemetery				Suitland, Maryland											
24. FUNERAL DIRECTOR																25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. S. Emery																DATE DEC 2 1968		Charles Judge	
Cheverly-Wheatley FH, 1500 W. Brad. Rd. Alex.																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16364

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1637

1. DECEASED NAME (Type or print) Emma		First L.	Middle Juenemann	Last	2a. DATE OF DEATH Month Nov. Day 17 Year 1968		2b. HOUR 9:17
3. SEX Female	4. RACE White		5. DATE OF BIRTH Dec. 13, 1889		6. AGE (In years last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) Wash. D. C.	7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md		
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Sacred Heart Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN LaPlata	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Star Rt. 2	
14. FATHER'S NAME First Adolph Middle Jouvenal Last				15. MOTHER'S MAIDEN NAME First Carrie V. Middle Whitemore Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 577-05-4078		17. INFORMANT Address Lois M. Isham Star Rt. 2 LaPlata, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease with DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months 1/24/65							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) did not attended the deceased from 1/24 , 19 65 , to 11/16 , 19 68 , that (I) was last saw the deceased alive on Nov. 16 , 19 68 and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) we (did) not view the body after death.							
22b. SIGNATURE Thomas F Collins DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED Nov. 18, 1968	
22d. PHYSICIAN'S NAME (Type) Thomas F Collins, M.D.				22e. ADDRESS 2600 Queens Chapel Road			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-21-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Pr. Geo. Md.	
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. S. E.				25a. SIGNED BY REGISTRAR NOV 21 1968 DATE		25b. REGISTRAR'S SIGNATURE William A. ...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/60

16365

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1657

1. DECEASED-NAME (Type or print) XXKAIKX, First Middle Last			2a. DATE OF DEATH November ^{Month} 9 ^{Day} 1968 ^{Year}		2b. HOUR 10:40	
3. SEX Male		4. RACE Caucasion		5. DATE OF BIRTH 9-28-94		6. AGE (In years last birthday) 74 YRS.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) E. Leland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Foreman Beth Steel Co.		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY Baltimore Sparrowspoint		13c. CITY OR TOWN 511 F. Street		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last John Kaiser			15. MOTHER'S MAIDEN NAME First Middle Last Lillian Willy			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWI
16b. SOCIAL SECURITY NO. 213-07-8732			17. INFORMANT (Son) Mr. John R. Kaiser, 4708 Edgewood Rd.			Address College Pk. Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial pulmonary arterial embolus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>recent</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION 10-17-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED cholecystitis, lithiasis		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>10-12</u> , 1968, to <u>11-9</u> , 1968, that (I) (we) lost saw the deceased alive on <u>11-9</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>D. R. Purdie MD</u> DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/9/68
22d. PHYSICIAN'S NAME (Type) <u>D. R. Purdie</u> M. D.				22e. ADDRESS <u>E. Leland Hospital, Riverdale, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/13/68		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park		23d. LOCATION (City or Town) (County) (State) Dorsey, Maryland
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR DATE NOV 15 1968		25b. REGISTRAR'S SIGNATURE <u>f Charles Judge</u>



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in (Page 1), 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16368

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-3-68

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED			Month Day Year			2b HOUR			
Paul B Keener						11-13-68			1955			35am			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR	8 UNDER 24 HRS	2c DATE PRONOUNCED DEAD			2d HOUR						
Male	White	2-5-1911	57 YRS			11 13 68 1955			57am						
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md						
West Va		U S A					Prince George's								
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY						
Cheverly			Prince George Hospital			Chief engineer			hospital						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c INSIDE CITY LIMITS?			13e STREET AND NUMBER						
Maryland			Prince George's Bladensburg			YES <input type="checkbox"/> NO <input type="checkbox"/>			5000 Townsend Way						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
Bernard R Keener			Daisy Sprigston												
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS						
yes			234 14 2254			Mary Ellen Keener			Bladensburg, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>over 4 yrs.</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f LOCATION Street or R.F.D. No			City or Town			County		State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED						
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			11-13-68						
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)						
Burial			Nov 16, 1968			Mt Olive Baptist Cemetery			Salem Doddridge West Va						
24 FUNERAL DIRECTOR						ADDRESS			25a REC'D BY REG STRAR		25b REG STRAR'S SIGNATURE				
F. Gasch's Sons						Hyattsville, Md.			NOV 18 1968		Charles Judge				

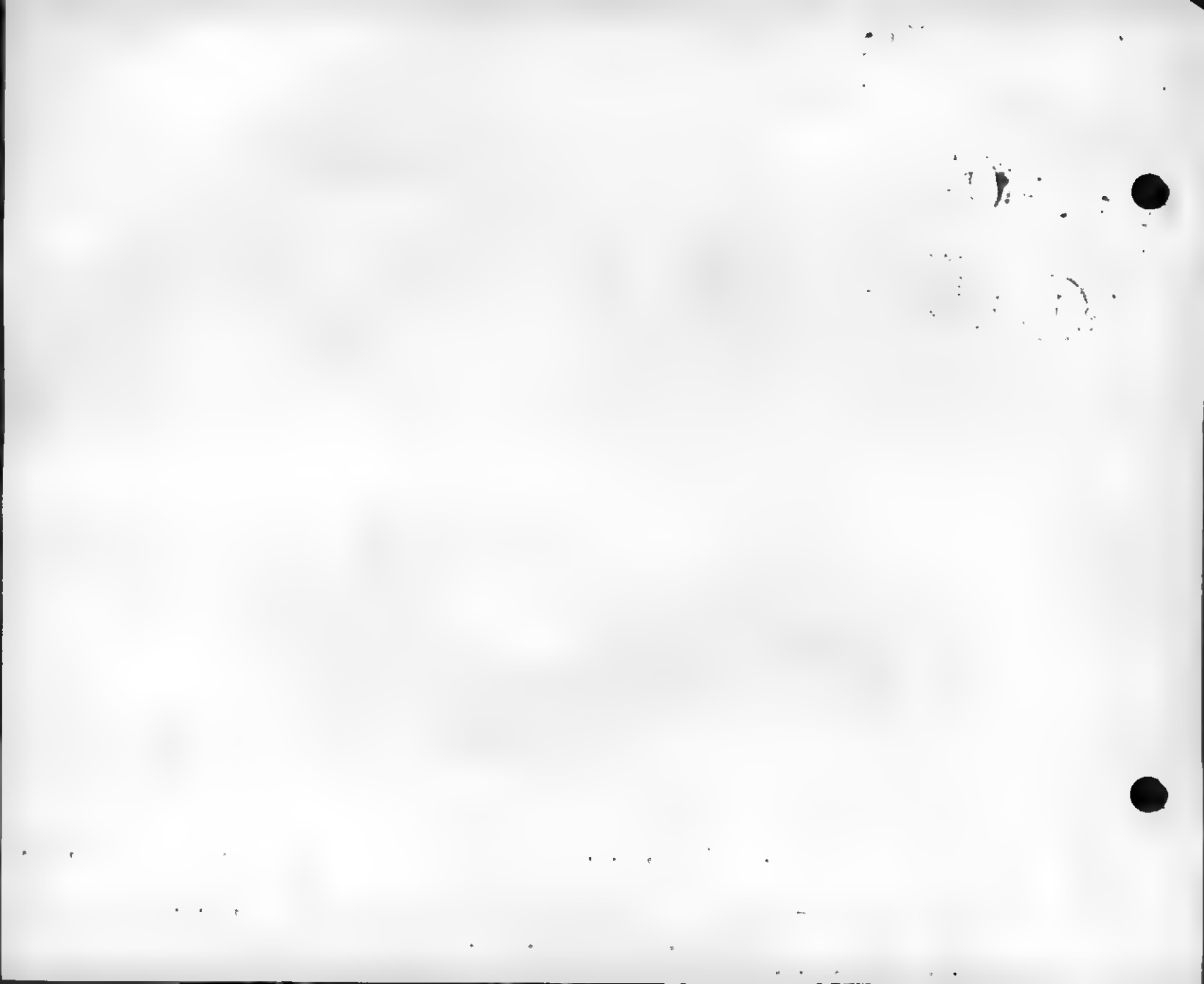


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16367										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16381		
CERTIFICATE OF DEATH																						
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			Month		Day		Year		2b. HOUR				
Crosby							Kelly		11-30-68			11		30		68		10:50 PM				
3 SEX			4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. BIRTHPLACE (State or foreign country)		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Male			White		11-18-1885		83 YRS		Wash. D.C.		X		Prince Georges		Lanham		Magnaolia Gardens		VETERINARIAN			
13a. USUA. RESIDENCE (Where deceased lived, if institution address an)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
D.C.					WASHINGTON		YES <input type="checkbox"/> NO <input type="checkbox"/>		2924 MILLS AVE. N.E		WILLIAM B.		HALLIE		NO				MRS. MARTHA E. SMITH, SISTER,		PHIL. PA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		1 day		1 week			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		DUE TO, OR AS A CONSEQUENCE OF		CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		1 day		1 week			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		21g. LOCATION	
					YES <input type="checkbox"/> NO <input type="checkbox"/>						HOUR A.M. Month Day Year				While <input type="checkbox"/> Not while <input type="checkbox"/>				Street or R.F.D. No		City or Town	
											P.M.				at work <input type="checkbox"/> at work <input type="checkbox"/>				County		State	
22a. I certify that (I) (this hospital) attended the deceased from			19 67, to		11-30, 19 68, that (I) (we) last saw the deceased alive on		11-30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED							
									Leon R. Levitsky, M.D.													
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		23e. LOCATION (County)		23f. LOCATION (State)		23g. LOCATION (City or Town)		23h. LOCATION (County)		23i. LOCATION (State)					
Burial			12-3-1968		Congressional Cemetery		Washington, D.C.															
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REC'D BY REGISTRAR		25d. REGISTRAR'S SIGNATURE		25e. REC'D BY REGISTRAR		25f. REGISTRAR'S SIGNATURE		25g. REC'D BY REGISTRAR		25h. REGISTRAR'S SIGNATURE		25i. REC'D BY REGISTRAR		25j. REGISTRAR'S SIGNATURE	
Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016			DEC 5 1968		Y. Charles Y. Charles																	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16368

16332

1. DECEASED NAME (Type or print) DAISY PEARL KEMPER			2a. DATE OF DEATH Month 11 Day 25 Year 68			2b. HOUR 4⁰⁰ A M	
3. SEX F		4. RACE W		5. DATE OF BIRTH APRIL 2, 1908		6. AGE (In years last birthday) 60 YRS	
7a. BIRTHPLACE (State or foreign country) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE Md.	
10. CITY OR TOWN OF DEATH LAUREL		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 227 GORMAN AVE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (Where deceased lived, if inst tut an. Residence before admission) STATE MD		13b. COUNTY PR. GEO		13c. CITY OR TOWN LAUREL		13e. STREET AND NUMBER 227 GORMAN AVE	
14. FATHER'S NAME First Middle Last GRANT HUMPHRIES				15. MOTHER'S MAIDEN NAME First Middle Last MOLLY MCDANIEL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT HAROLD KEMPER			
				Address ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis							1-2-
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Atherosclerosis							3 Yrs
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis							10 Yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Bronchitis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 8/17, 1963 to 5/16, 1968 , that (I) (we) last saw the deceased alive on 11/16, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. M. Warren M.D.				22c. DATE SIGNED 11/25/68		22d. PHYSICIAN'S NAME (Type)	
				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11-27-68		23c. NAME OF CEMETERY OR CREMATORY BOWYER CEM.		23d. LOCATION (City or Town) (County) (State) COVINGTON VA	
24. FUNERAL DIRECTOR Concedran Funeral Home, Laurel Md				25a. REC'D BY REGISTRAR NOV 29 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



16369

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	20. DATE OF DEATH Month Day Year		2b. HOUR P	
Doris		D.		King	November 22, 1968		11:55M	
3. SEX	Female		4. RACE	White		5. DATE OF BIRTH	6. AGE (In years lost birthday)	
						6/9/21	47 YRS	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia	U.S.A.				Prince George's Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly	Prince George's Gen. Hosp.		House Wife					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Kentland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7317 Forest Road	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Herman	W.		Balderson	Nattie				Greenwell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No				Raymond L King Sr		7317 Forest Rd Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>485X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Brucella pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic brucella pneumonia</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <u>491X Chronic heart</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCAT ON Street or RFD No. City or Town County State				
22a. I certify that it (this hospital) attended the deceased from <u>Oct. 30, 1968</u> , to <u>Nov. 22, 1968</u> , that it (we) last saw the deceased alive on <u>November 22, 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, it (we) (did) not view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
Fidel J. Quintana		11-23-68		FIDEL J. QUINTANA		8715 First Ave. S. Spring, Ark		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		11/25/1968		Fort Lincoln Cemetery		Colmar Manor Maryland		
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. REC'D BY REGISTRAR		24c. REGISTRAR'S SIGNATURE		
Lee Funeral Home		300 4th St NW Washington DC		DATE NOV 27 1968		Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

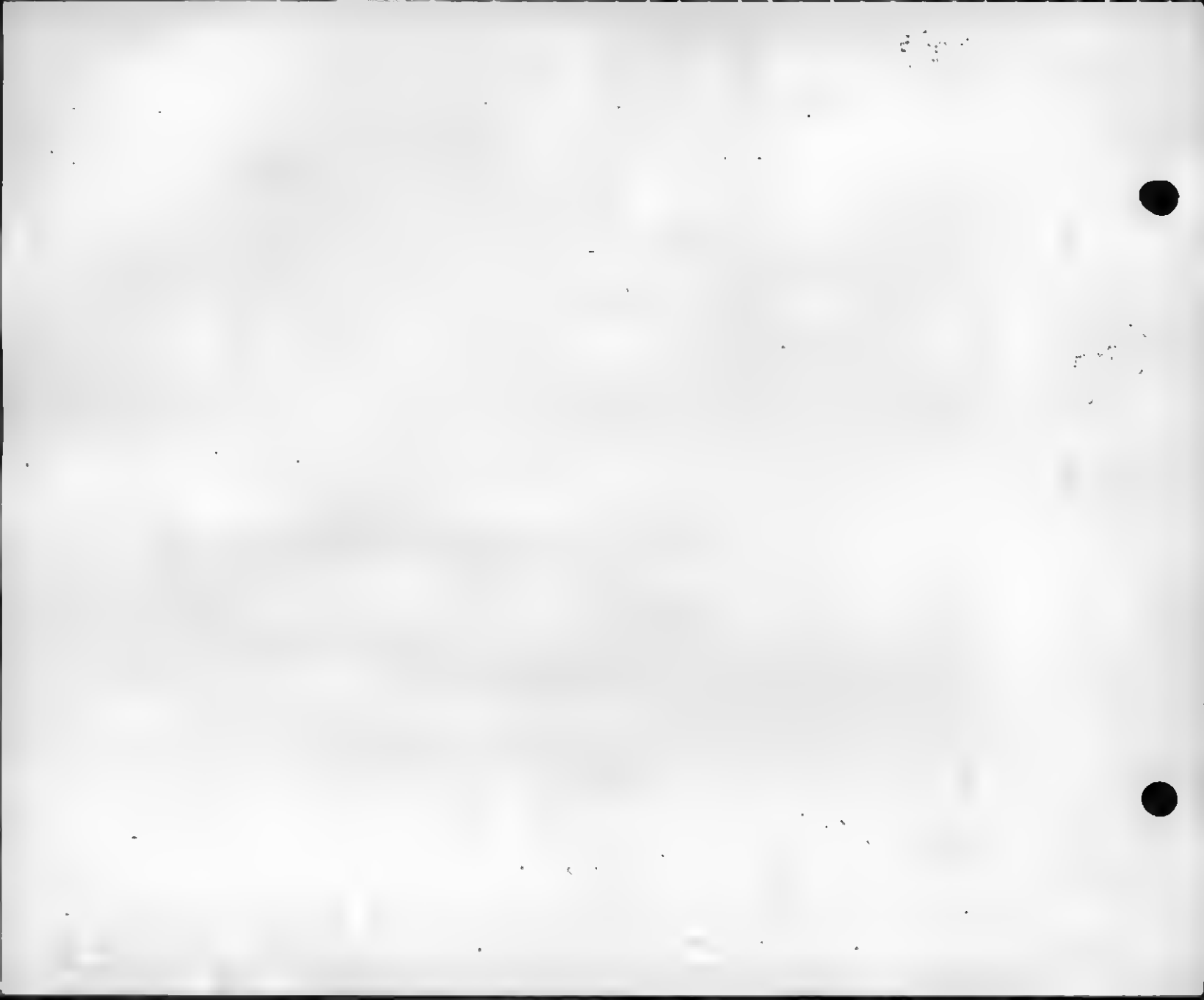


**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>16370</div> <div> <div>1</div> <div>16384</div> </div>									
<div> <div>1. DECEASED NAME (Type or Print)</div> <div>First Middle Last</div> <div>Glenn Edward Kitchin</div> </div>									
<div>3 SEX</div> <div>Male</div>		<div>4 RACE</div> <div>White</div>		<div>5 DATE OF BIRTH</div> <div>3-23-1918</div>		<div>6 AGE (In years last birthday)</div> <div>50 YRS</div>		<div>7a DATE KNOWN OF DEATH</div> <div> <div>Month Day Year</div> <div>11-24-68 11:30pm</div> </div>	
<div>7b BIRTHPLACE (State or foreign country)</div> <div>Kansas</div>		<div>7c CITIZEN OF WHAT COUNTRY?</div> <div>U S A</div>		<div>8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>9. COUNTY OF DEATH</div> <div>Prince George's Md</div>		<div>2c DATE PRONOUNCED DEAD</div> <div> <div>Month Day Year</div> <div>11-24-68 11:45pm</div> </div>	
<div>10 CITY OR TOWN OF DEATH</div> <div>Cheverly</div>			<div>11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>Prince George Hospital</div>			<div>12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)</div> <div>Printer</div>		<div>12b KIND OF BUSINESS OR INDUSTRY</div> <div>U S Government</div>	
<div>13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE</div> <div>Maryland</div>			<div>13b. COUNTY</div> <div>Prince George's</div>			<div>13c. CITY OR TOWN</div> <div>Cheverly</div>		<div>13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></div>	
<div>13e STREET AND NUMBER</div> <div>6131 Montrose Avenue</div>									
<div>14. FATHER'S NAME First Middle Last</div> <div>Wilbur G. Kitchin</div>					<div>15 MOTHER'S MAIDEN NAME First Middle Last</div> <div>Cora Williams</div>				
<div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>yes</div>			<div>16b. SOCIAL SECURITY NO. (If yes give war or dates of service)</div> <div>WW 11 512 05 1784</div>		<div>17. INFORMANT ADDRESS</div> <div>Opal Kitchin Cheverly, Md.</div>				
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure</div> <div> <div> <div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</div> <div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>Severe coronary arteriosclerosis</div> </div> </div> <div> <div>(b)</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> </div> <div> <div>(c)</div> </div> </div> <div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div>minutes over 5 yrs.</div>									
<div>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)</div> <div>4 1 0 1</div>									
<div>19a. DATE OF OPERATION</div>			<div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</div>			<div>20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>			
<div>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/></div> <div>CAUSE OF DEATH</div>			<div>21b. TIME OF INJURY Month, Day, Year</div> <div>HOUR A.M. P.M. 19</div>		<div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)</div>				
<div>21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></div>		<div>21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)</div>		<div>21f. LOCATION Street or R.F.D. No</div>		<div>City or Town</div>		<div>County State</div>	
<div>22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div>									
<div>ACTUAL SIGNATURE</div> <div>John Kehoe MD</div>					<div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div> <div>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div> <div>ADDRESS (Street, city, town, or county)</div>				
<div>EXAMINER'S NAME (Type)</div> <div>John Kehoe MD Riverdale, Md.</div>					<div>22b. DATE SIGNED</div> <div>11-25-68</div>				
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>		<div>23b. DATE</div> <div>Nov 27, 1968</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Ft Lincoln Cemetery</div>		<div>23d. LOCATION (City or Town) (County) (State)</div> <div>Colmar Manor Pro Geo Md.</div>			
<div>24. FUNERAL DIRECTOR</div> <div>F. G. Sch's Sons Hyattsville, Md.</div>					<div>25a. REC'D BY REGISTRAR</div> <div>NOV 27 1968</div>		<div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1088

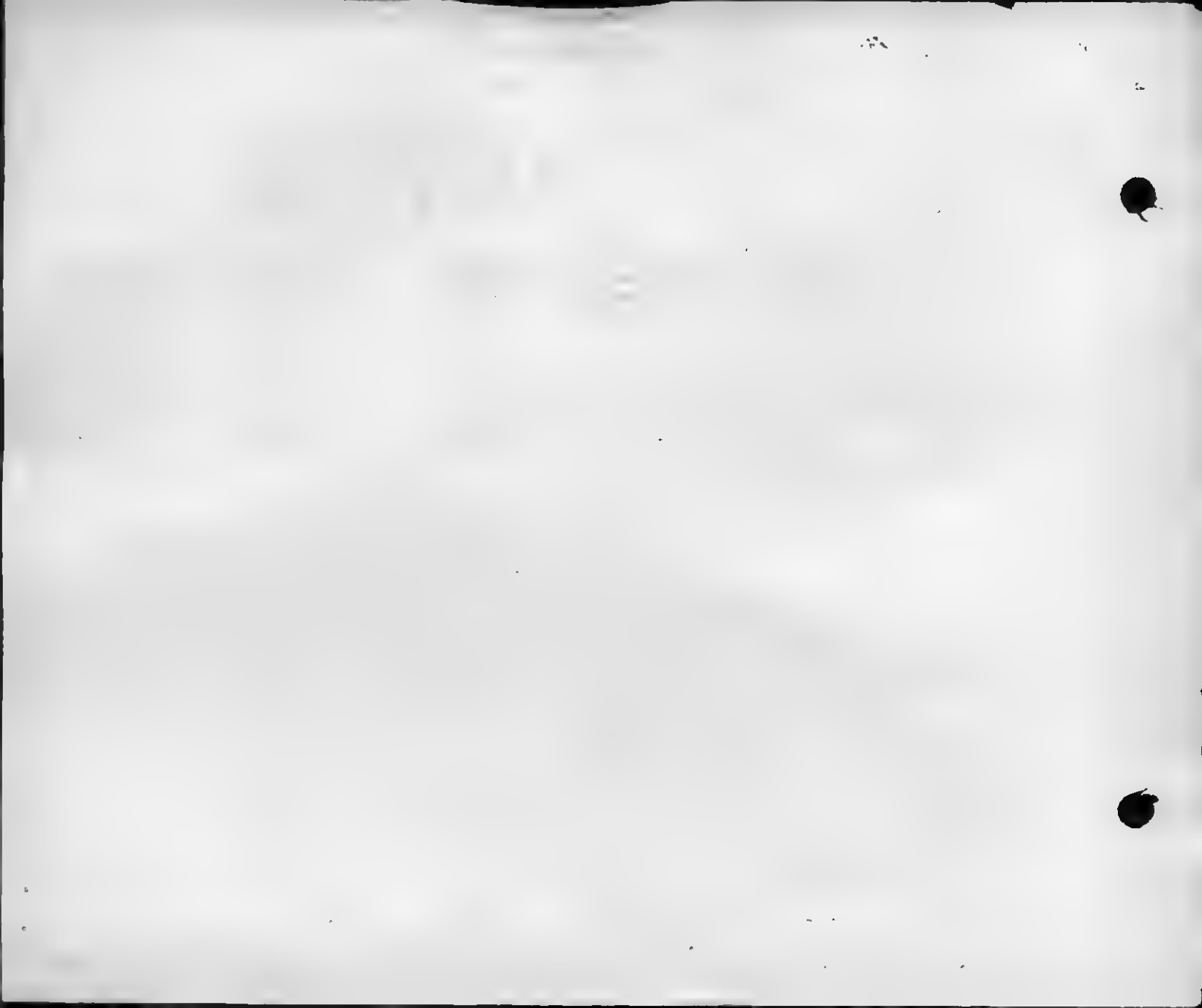
CERTIFICATE OF DEATH

Reg. Dist. No.

16371

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3450 Toledo Terrace		d. STREET ADDRESS 3450 Toledo Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Peter Middle T. Last Kossiaras		4. DATE OF DEATH Month 11 Day 3 Year 1968	
5. SEX male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-1895
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Anastasios Kossiaras		14. MOTHER'S MAIDEN NAME - Voutsas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 126-09-5461	
17. INFORMANT Mr. Thomas Kossiaras, Son, same as item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (1) Cardiac arrest DUE TO (2) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (3) Generalized arteriosclerosis DUE TO (4) Cirrhosis of the Liver (Cardiotype)		INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 years 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1960 , 19 11-3 , 19 68 , that I last saw the deceased alive on 10-30 , 19 68 , and that death occurred at 8 a.m. , from the causes and on the date stated above. ACTUAL SIGNATURE James T. Burns M.D. 1835 1st Ave. NW. 11-3-68 PHYSICIAN'S NAME (Type) JAMES T. BURNS Wash., D.C. 20006			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-5-1968	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Md. Bladensburg, Prince Georges Co.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016		24a. REC'D BY REGISTRAR NOV 7 1968	
24b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

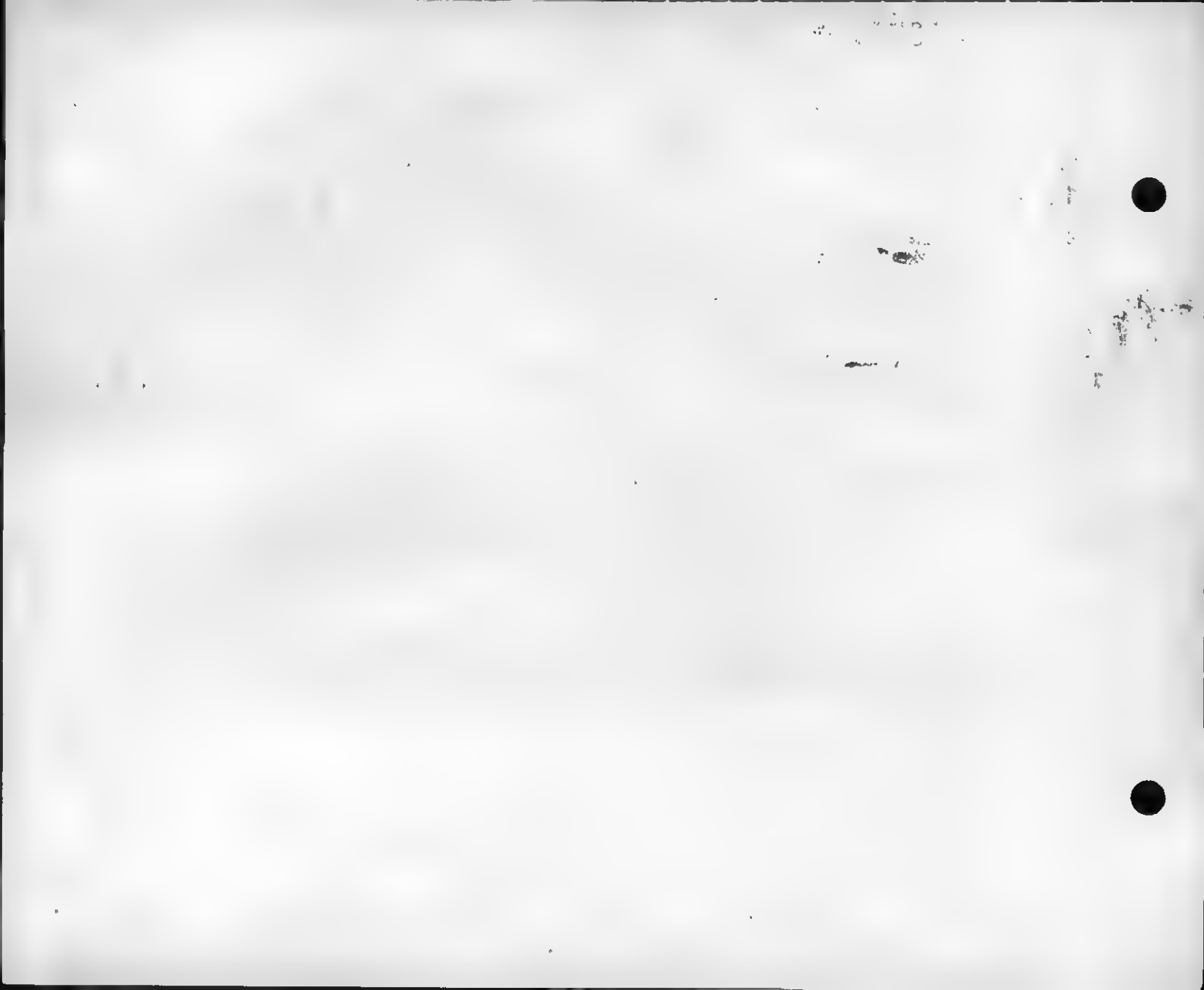
Item 78-14-409 2-14-409 2-14-409 16377 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										16386			
1. DECEASED-NAME (Type or Print)		DELPHIA KATHERINE Kraft				2a. DATE KNOWN OF DEATH MATED		11-27-68		2b. HOUR 19 PM			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD		11		2d. HOUR 3:30 PM			
Female	White	1/3/12	58 YRS			Month Day Year							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Prince George's							
Va.		USA											
10. CITY OR TOWN OF DEATH Hyattsville			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 4513 Burlington Road			12a. USUAL OCCUPATION (Kind of work done during previous life if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY None				
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13c. CITY OR TOWN Hyattsville			3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 4513 Burlington Road				
14. FATHER'S NAME First Middle Last Dela Davis Gilmer			15. MOTHER'S MAIDEN NAME First Middle Last Esta Alice Bowman										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Unknown			16b. SOCIAL SECURITY NO Unknown			17. INFORMANT (Mother) Esta A. Gilmer, 715 Liberty St., Harrisburg, Va.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute alcoholism													
3039 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
3220													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE John Kehoe MD				CHIEF MED. CAL. EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 11-29-68					
EXAMINER'S NAME (Type)				ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>									
				DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>									
				ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12-8-68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince George's Co., Md.							
24. FUNERAL HOME		Home, Mt. Rainier, Md.		25a. RECD BY REGISTRAR DEC 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 5 days after death.

16373										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										1638				
Item #5, Film G406 11/21/68 km										CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print) Annie					First May Middle Kronheim Last					2a. DATE OF DEATH Nov. Month 9 Day 65 Year					2b. HOUR 4:05 AM									
3 SEX Female					4 RACE White					5 DATE OF BIRTH Oct 29, 1903					6 AGE (In year last birthday) 65 YRS					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 				
7a BIRTHPLACE (State or foreign country) Va					7b CITIZEN OF WHAT COUNTRY? U S A					8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9 COUNTY OF DEATH Pro George's Md.									
10 CITY OR TOWN OF DEATH Forestville					11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Regent Nursing home					12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Food Mgr					12b KIND OF BUSINESS OR INDUSTRY Drug Store									
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md					13b. CITY OR TOWN Pro Geo Colmar Manor					13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13d. STREET AND NUMBER 4105 Newton st									
14 FATHER'S NAME John A Bradshaw					First John A Middle Bradshaw Last					15 MOTHER'S MAIDEN NAME Fannie M Zimmerman					First Fannie M Middle Zimmerman Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)					16b. SOCIAL SECURITY NO 577 10 1407D					17 INFORMANT Phyllis Seiferth					Address Colmar Manor, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Right Pulmonary Carcinoma of Lungs, Middle Lobe, with Abscess Formation 1621 DUE TO, OR AS A CONSEQUENCE OF Right Bronchial Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) 															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) None																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State 														
22a. I certify that (I) (this hospital) attended the deceased from Sept 10, 1965 , to Nov 8, 1965 , that (I) (we) last saw the deceased alive on Nov 8, 1965 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE Oliver B Bond					DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 11/9/68														
22d. PHYSICIAN'S NAME (Type) OLIVER B BOND					22e. ADDRESS 6772 LANHAM					22f. ADDRESS 6772 LANHAM					22g. ADDRESS 6772 LANHAM									
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation					23b. DATE Nov 12, 1968					23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory					23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.									
24. FUNERAL DIRECTOR F Gasch's Sons					ADDRESS Hyattsville, Md.					25a. REC'D BY REGISTRAR DATE NOV 18 1968					25b. REGISTRAR'S SIGNATURE Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR A M	
Raymond M. Lambert					Nov 24, 1968		11 A	
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
male		white		April 3, 1920		48 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
West Va		U S A				Prince George's Md.		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work ing life, even if ret. red.)		12b. KIND OF BUSINESS OR INDUSTRY		
Bowie		12314 Thompson Road Bowie		Retired Supt construction D C Govt.				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Res dence before adm ssion) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md		Prince George's		Bowie		YES <input type="checkbox"/> NO <input type="checkbox"/>		12314 Thompson Road
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last				
Willie L Lambert				Maggie L Trainer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT		Address		
no		232 24 4271		Sara V. Lambert		Bowie, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>								<u>2 days</u>
1621 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchogenic Carcinoma</u>								<u>6 months</u>
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
1621								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
6/28/68		Bronchogenic Carcinoma						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (the hospital) attended the deceased from <u>May 3, 1968</u> to <u>Nov. 24, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Nov 24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)				
<u>Leonard P. Appel M.D.</u>		<u>Nov 24, 1968</u>		<u>LEONARD P. APPEL, M.D.</u>				
22e. ADDRESS		22f. ADDRESS						
		<u>3231 SUPERIOR LA. BOWIE, MD.</u>						
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Nov 27, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.		
24 FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
F. Gasch's Sons Hyattsville, Md.				DATE NOV 27 1968		<u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove cordon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15
30M REV 11-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
FLORENCE J. LEHMAN						Month Day Year NOV 16 1968			9:50 AM
3 SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE	WHITE		JUNE 6 1896			72 YRS			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH
PENN.			U.S.A.						PRINCE GEORGES Md.
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
RIVERDALE			LELAND MEM. HOSP			HOUSEWIFE			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13e STREET AND NUMBER	
MD.			PRINCE GEORGE			HYATTSVILLE		4018 MADISON ST.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
UNKNOWN			UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT			Address
No			579286013			DALTON G. LEHMAN			6708 AGER RD W HYATTSVILLE, MD
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>									<u>Sudden</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Diffuse Myocardial Ischemia</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>due to advanced Coronary Sclerosis</u>									<u>5 y.L.</u>
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
TRU									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/5</u> , 19 <u>54</u> , to <u>11/16</u> , 19 <u>68</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>10/29</u> , 19 <u>68</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
<u>Daniel B. Washington M.D.</u>								<u>11/18/68</u>	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
DANIEL B. WASHINGTON			5802 Ridge Field Rd BETHESDA, MD 20816						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
BURIAL			NOV 19 1968			FT. LINCOLN CEM			CORRIAN MANOR MD
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
WW Chambers Co.			1400 CHAMBERS ST N.W. WASH. D.C.			DATE NOV 26 1968		<u>James</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16378

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16378

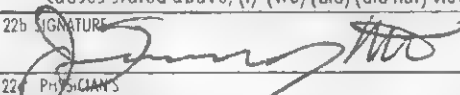

1 DECEASED-NAME (Type or print) First Middle Last Helen R. Lewis			2a. DATE OF DEATH Month Day Year 11-22-68			2b. HOUR 7:20 ^{AM}	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 12-24-92		6. AGE (In years) last birthday 75 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) maid		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 5700 Baltimore Ave.,		14. FATHER'S NAME First Middle Last Charles Harry Lewis		15. MOTHER'S MAIDEN NAME First Middle Last Edith V.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 216 22 1091A		17. INFORMANT (friend) Address Miss Margaret Rose/ Medical Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Insufficiency 4 (b) GEN. ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4 ACUTE VIREMIA							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE YEAR UNKNOWN
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11-3, 1968, to 11-22, 1968, that (I) (we) last saw the deceased alive on 11-21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. J. Houmann		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 22 NOV 68	
22d. PHYSICIAN'S NAME (Type) C. J. Houmann, M.D.		22e. ADDRESS 4408 Queensbury Rd., Riverdale, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 26, 1968		23c. NAME OF CEMETERY OR CREMATORIUM Glenwood Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D. C.	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 27 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge							



16377

16394

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last MILDRED AGNES LEWIS			2a. DATE OF DEATH Month Day Year NOVEMBER 3 1968			2b. HOUR A M 6:15	
3. SEX FEMALE		4. RACE CAU		5. DATE OF BIRTH 23 JAN 1902		6. AGE (In years last birthday) 66 YRS.	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE'S Md	
10. CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAF HOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) VIRGINIA		13b. CITY OR TOWN LOTTSBURG		13c. INSIDE CITY (IM-157) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER BOX 95	
14. FATHER'S NAME First Middle Last ZACHARIAH HUGHES			15. MOTHER'S MAIDEN NAME First Middle Last ANNA SISSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <input checked="" type="checkbox"/> unknown <input type="checkbox"/> (If yes give war or dates of service)		16b. SOC. SEC. NO. 228-32-7443		17. INFORMANT Address DAUGHTER 5203 JANICE, TEMPLE HILL, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>gram negative pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic carcinoma of colon</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1538							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 22 AUG , 19 68 , to 3 NOV , 19 68 , that (I) (we) last saw the deceased alive on 3 NOV 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE 				DEGREE CAPT, USAF, MC		22c. DATE SIGNED 3 NOV 1968	
22d. PHYSICIAN'S NAME (Type) JOHN J. SIMONAITIS, CAPT, USAF, MC				22e. ADDRESS MALCOLM GROW USAF HOSPITAL ANDREWS AFB, WASH, D.C. 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 5-68		23c. NAME OF CEMETERY OR CREMATORY Bethany Bapt. Cemetery		23d. LOCATION (City or Town) (County) (State) Callao, Virginia	
24. FUNERAL DIRECTOR Simmons Bros				ADDRESS Wash, DC		25a. REC'D BY REGISTRAR NOV 6 1968	
25b. REGISTRAR'S SIGNATURE 							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16378

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1639

1 DECEASED-NAME (Type or print) First Middle Last ROBERT LEE LOWERY			2a DATE OF DEATH Nov Month 23 Day 1968 Year			2b HOUR M					
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 11-5-1909		6 AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George Md					
10 CITY OR TOWN OF DEATH Chesapeake		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Prince George		13c CITY OR TOWN Parkland		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 103 Maryland			
14 FATHER'S NAME First Middle Last SYDNEY H. LOWERY			15 MOTHER'S MAIDEN NAME First Middle Last LOUISE DAVIS								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO 578-24-4808		17 INFORMANT EDITH C. LOWERY		Address same as 13a BALE					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Apparent Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) severe refractory congestive failure PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pulmonary effusions, Chronic, bilateral										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that (1) (this hospital) attended the deceased from 5 Sept, 1968, to 11/23/1968, that (1) (we) last saw the deceased alive on 11/16/1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b SIGNATURE J. F. Lowe, M.D.		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 11/23/1968					
22d PHYSICIAN'S NAME (Type) J. F. Lowe		22e ADDRESS 6056 Central Ave Capital Heights, Md.									
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE 11-25-1968		23c NAME OF CEMETERY OR CREMATORY Christ Church		23d LOCATION (City or Town) Chaptico		(County) Maryland		(State)	
24 FUNERAL DIRECTOR, Mullerly		ADDRESS 131-11th St SE D.C.		25a REC'D BY REG. STRAR DATE NOV 27 1968		25b REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

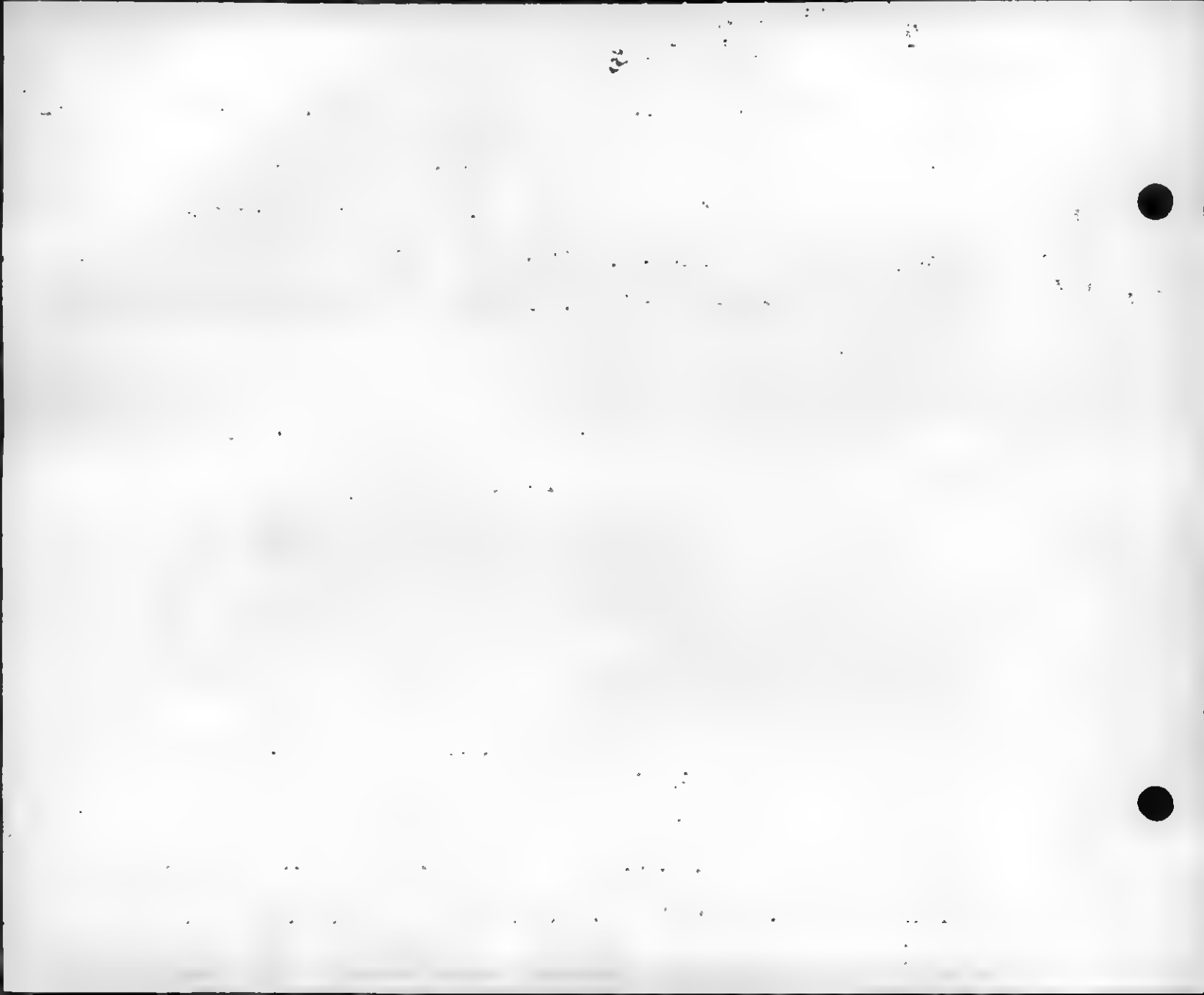
VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16379

16379

1. DECEASED NAME (Type or print) Nicholas J. Lutzio		2a. DATE OF DEATH Month Nov. Day 18 , Year 1968		2b. HOUR 6:15 P.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Oct. 27, 1907	
6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Pa		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Divorced <input type="checkbox"/>	
9. COUNTY OF DEATH Prince George's Md		10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Insurance agent		12b. KIND OF BUSINESS OR INDUSTRY Insurance		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	
13b. CITY OR TOWN Prince George's		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 8604 Fremont Street	
14. FATHER'S NAME First Middle Last Joseph Lutzio		15. MOTHER'S MAIDEN NAME First Middle Last Maria Pipino		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) generalized carcinomatous 1517 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) carcinoma of stomach DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1517 X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (the doctor) attended the deceased from Nov. 7, 1968 , to Nov. 18, 1968 , that (I) (we) last saw the deceased alive on Nov. 18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A.S. Banisar		DEGREE MD		22c. DATE SIGNED 11-19-68	
22d. PHYSICIAN'S NAME (Type) Amir Banisar, M. D.		22e. ADDRESS 6323 Landover Rd., Cheverly, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 21, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Cecilia's Cem	
23d. LOCATION (City or Town) (County) (State) Coatesville, Pa		24. FUNERAL DIRECTOR Donald J. H. Paul Md			
25a. REC'D BY REGISTRAR DATE NOV 25 1968		25b. REGISTRAR'S SIGNATURE Thomas Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in item 18. Give Pages 1 and 2 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form 303. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1055.

VR A15ME (S)
10M REV 1/68



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

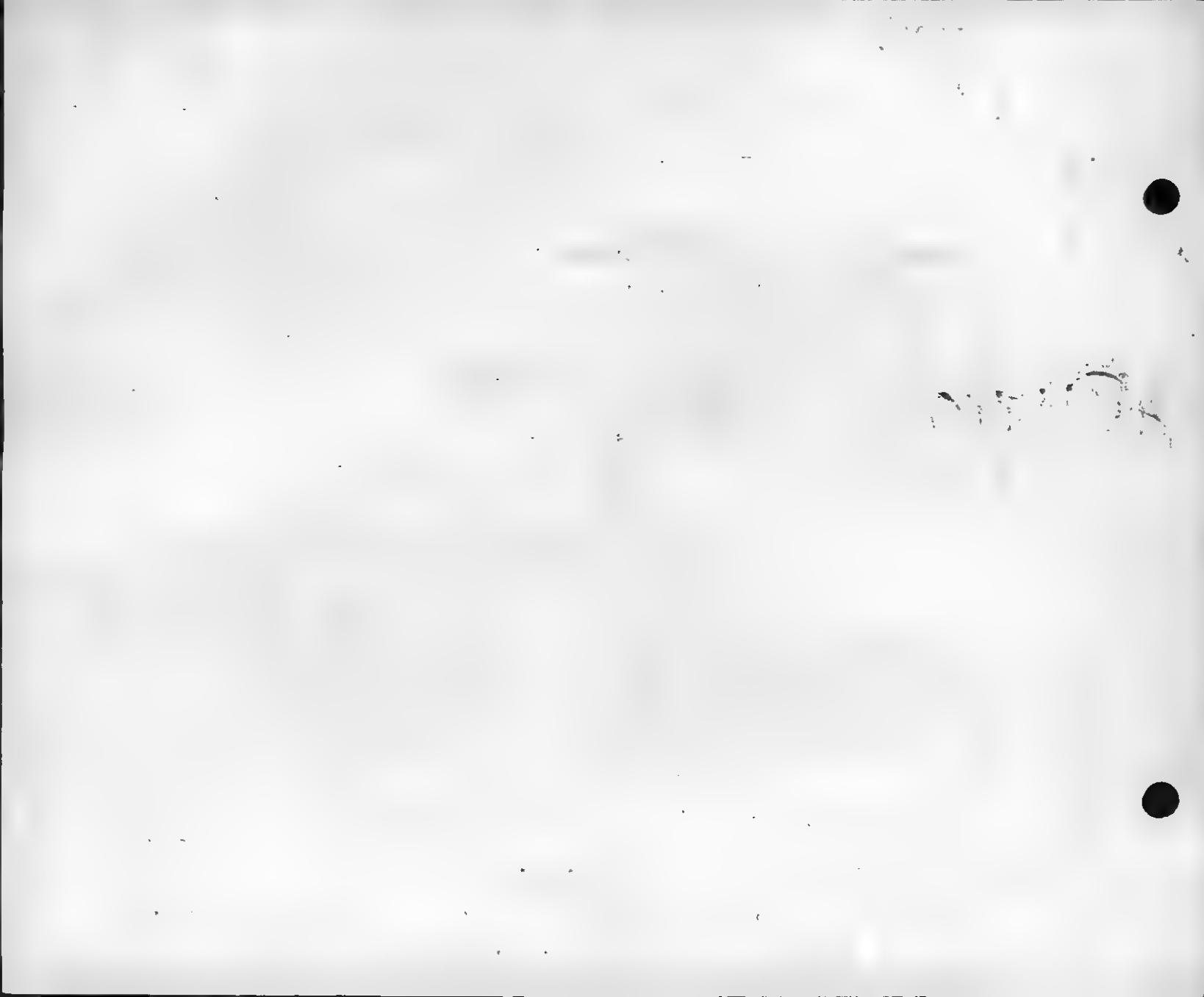
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16381

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16389

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH Month Day Year			2b HOUR		
Beatrice			Mary			Mamo			11-13-68 19 2:00am		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR
Female	White	11-29-1925	42 YRS					11 13 68			19 7:10am M
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Pa			U S A						Prince George's Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Hospital			Housewife			Home		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Maryland			Prince George's			Bowie			YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER			12207 Maler Lane								
14 FATHER'S NAME First Middle Last						15 MOTHER'S MAIDEN NAME First Middle Last					
Frank Hills						Katherine Fitzgerald					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS					
no						Bartholomew G Mamo Bowie, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhagic shock DUE TO, OR AS A CONSEQUENCE OF Rupture of oesophageal varix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes minutes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED		
John Kehoe MD			Riverdale, Md.						11-14-68		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			Nov 16, 1968			Mt Olivet Cemetery			Washington D. C.		
24 FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
F. Gasch's Sons Hyattsville, Md.						NOV 18 1968			J. Charles Yarnall		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in blank in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16382

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16396

Items #7a, b, & 8, Film MEDICAL EXAMINER'S CERTIFICATE OF DEATH

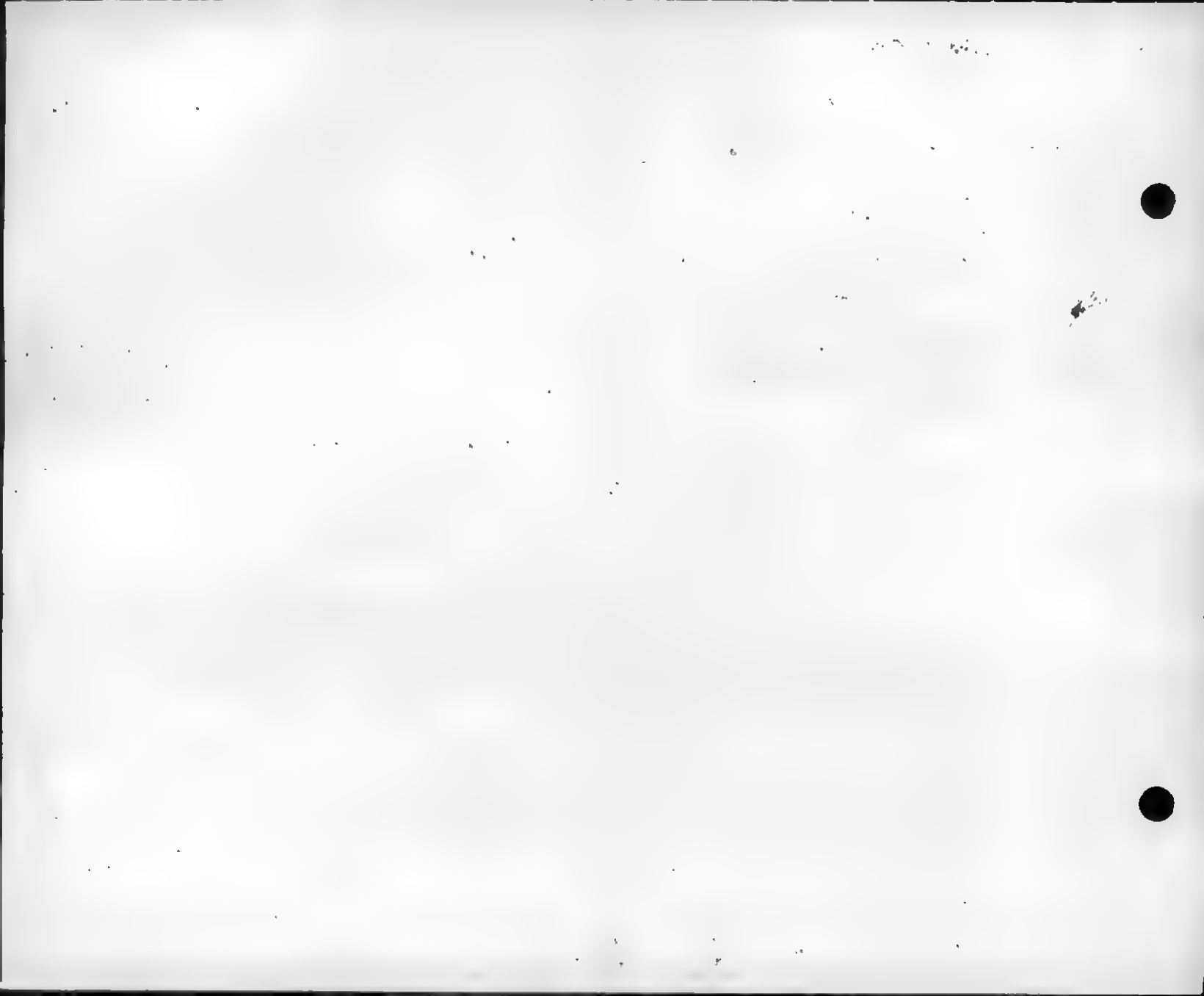
1 DECEASED NAME (Type or Print) Roy C Mangum Jr			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 11-9-68 1912:50am			2b. HOUR		
3 SEX Male	4 RACE Negro	5 DATE OF BIRTH 8-2, 1932	6 AGE (In years) 36 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	7 UNDER 24 HRS MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 11 9 68 193:20am M		
7a BIRTHPLACE (State or foreign country) North Carolina		7b. CT ZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md		
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY
13a USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland COUNTY Prince George's			13c. CITY OR TOWN Mitchellville		3a INSIDE CITY, APTS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER Rt. 1, Box 1020		
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3rd. degree burns of 100% body surface DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 916								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HO, R.A.M. 12:45am 11-9- 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Burned in house fire				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) home		21f LOCATION Street or R.F.D. No City or Town County State same as #13.				
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John Kehoe M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 11-10-68		
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE Nov 21, 1968		23c NAME OF CEMETERY OR CREMATORY Carver Memorial		23d LOCATION (City or Town) (County) (State) Lanham Md		
24 FUNERAL DIRECTOR Johnson & Jenkins F.H. Inc		ADDRESS Wash. DC 4804 E. Ave NW		25a REC'D BY REGISTRAR NOV 26 1968		25b REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR		
GREGORY SCOTT			MANIK			Month Day Year			11 26 68		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		F UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		CAUCASIAN		11/9/66		2 YRS.		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Wash. D.C.		U.S.A.				Prince George Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Brandywine			Brandywine Clinic								
13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Md.			Charles			Waldorf		YES		Rt 3, Box 505	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Wilfred			Mank Constance						Brown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address		
						Constance Mank			Rt. 3, Box 505 Waldorf Md		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYDROCEPHALUS</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
344X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21a. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No.			City or Town		County State
22a I certify that (I) (this hospital) attended the deceased from 11/20, 1968, to 11/26, 1968, that (I) (we) last saw the deceased alive on 11/26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c DATE SIGNED		
PHILIP C. BARTLETT									11/26/68		
22d. PHYSICIAN'S NAME (Type)			22e ADDRESS								
PHILIP C. BARTLETT			BRANDYWINE CLINIC						BRANDYWINE MD.		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial Nov. 24 1968						Shuman, C.W.			Waldoboro, Lincoln Maine		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
Hunt Funeral Home, Waldorf, Md						DATE NOV 22 1968			[Signature]		



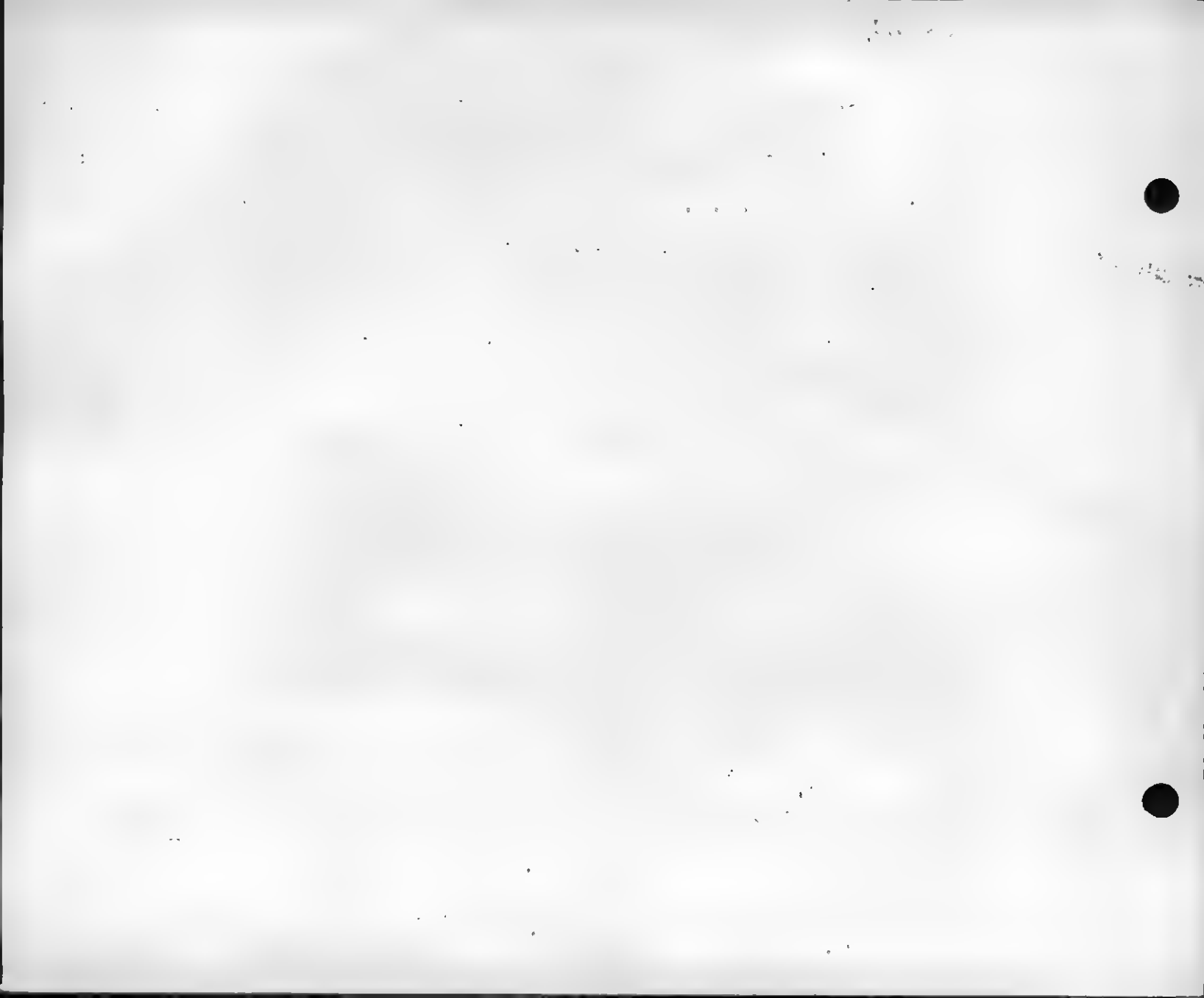
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 409 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 11-22-68 19 6:00am			2b HOUR		
Norma			Jeannine			Manning					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR
Female	White	3-19-1929	39 YRS					11 22 68			8:50am M
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Florida			U.S.A.						Prince George's Md.		
10. CITY OR TOWN OF DEATH			1 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			housewife					
13a U.S.A. RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Prince George's			Cheverly			6531 Landover Road		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
James L. Cook			Natalie Marcisonny								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute barbiturate intoxication</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <u>4702</u>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month Day Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			22b. DATE SIGNED			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
John Kehoe MD			Riverdale, Md.			11-22-68					
23a BURIAL CREMATION REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			11/26/68			Grosely Lake Com.			Starke, Florida		
24. FUNERAL DIRECTOR			ADDRESS			25g REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
Halley's Funeral Home Inc.			Md. Rainier Maryland			NOV 25 1968			Charles Judge		



CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) JOHN		First	Middle	Last	2a. DATE OF DEATH NOV Month 15 Day 68		2b. HOUR 6:40 AM
3. SEX Male	4. RACE White		5. DATE OF BIRTH May 27-1910		6. AGE (In years last birthday) 58 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) KANSAS	7b. CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.		
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Southern Md. Gen. Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U. S. GORT		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institut on admission) STATE Md		13b. COUNTY PR. Geo.		13c. CITY OR TOWN CLINTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 7325-BALLARD DR. SE		14. FATHER'S NAME First Middle Last John V. McCall		15. MOTHER'S MAIDEN NAME First Middle Last Eugenia McCall-7325-BALLARD DR. SE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO		17 INFORMANT Address CLINTON Md Eugenia McCall-7325-BALLARD DR. SE			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE PULMONARY EMBOLUS 4124 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (c) DISEASE WITH RECENT AVRICULAR FIBRILLATION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 MIN. 6 HRS.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 45-1 NONE							
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (if either, notify medical examiner) None		21b. TIME OF INJURY HOUR A.M. Month Day Year None		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) None			
21d. WHERE OCCURRED Home <input checked="" type="checkbox"/> or work <input type="checkbox"/> None		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) None		21f. LOCATION Street or R.F.D. No City or Town County State None			
22a. I certify that (I) (this hospital) attended the deceased from SEPT, 1958 to PRESENT , that (I) (we) last saw the deceased alive on NOV 15 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (d) (d) view the body after death.							
22b. SIGNATURE Arthur Shaver MD		22c. DATE SIGNED 11/13/68		22d. PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR. MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 16-68		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.		23d. LOCATION (City or Town) (County) (State) Clinton, Md.	
24. FUNERAL DIRECTOR Simmons Bros		ADDRESS Wash DC		25a. REC'D BY REGISTRAR NOV 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

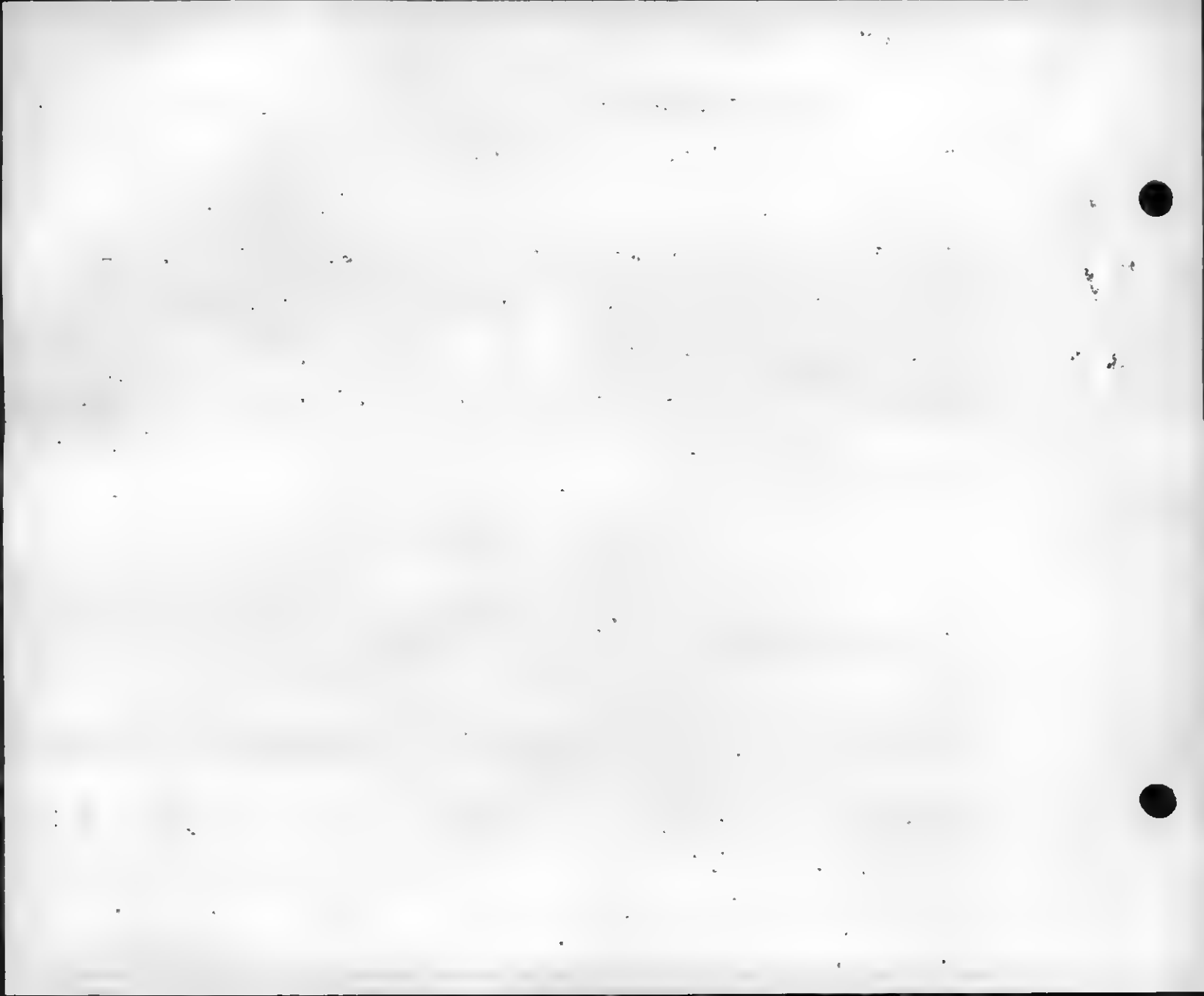
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16386

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16386

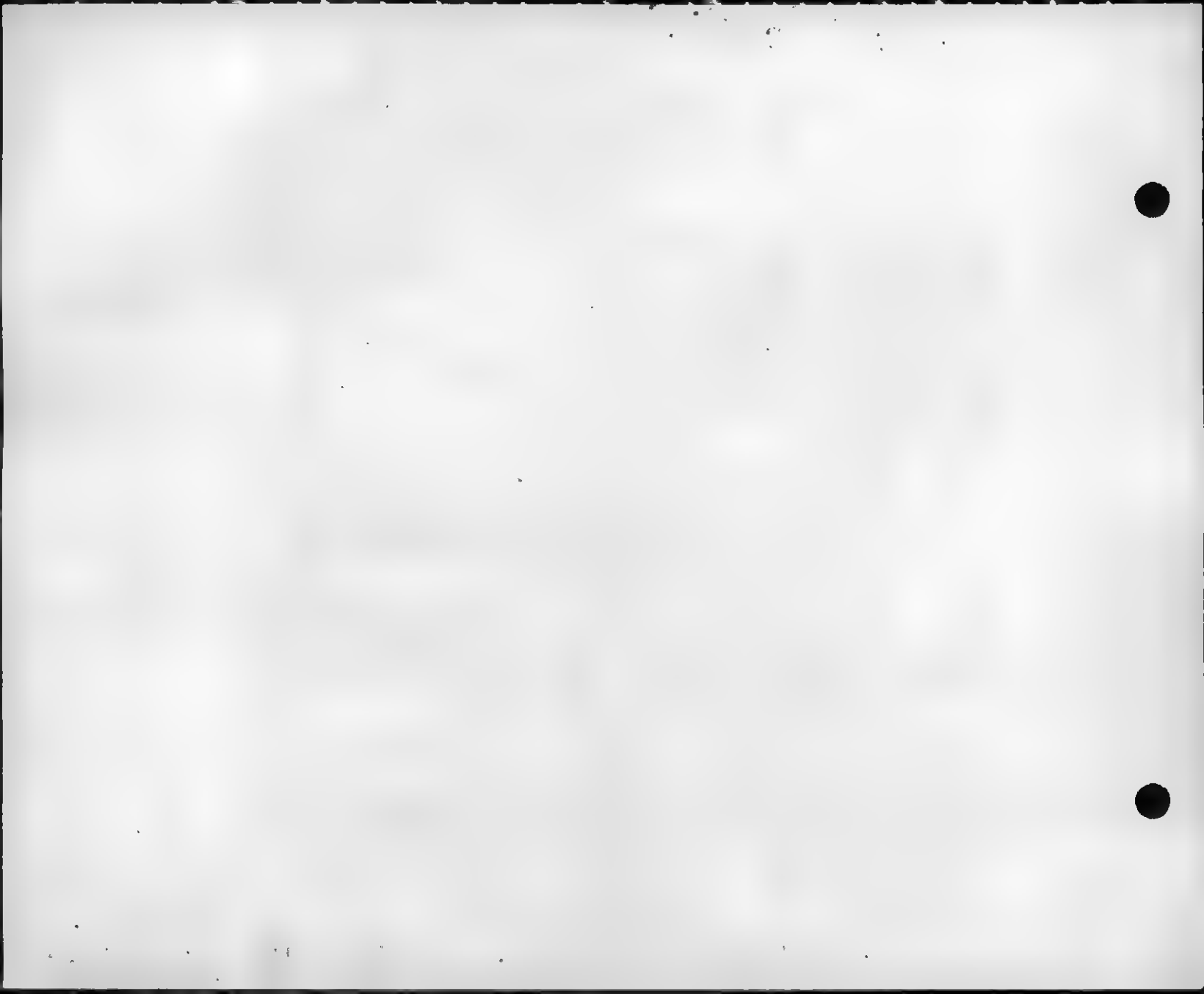
1. DECEASED-NAME (Type or print) William J. McCloskey			First Middle Last			2a. DATE OF DEATH Month November Day 16 , Year 1968			2b. HOUR 12:30 AM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH 9/12/27			6. AGE (In years last birthday) 41 YRS		
7a. BIRTHPLACE (State or foreign country) Penna.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Framer			12b. KIND OF BUSINESS OR INDUSTRY -		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland 13b. COUNTY Prince George's			13c. CITY OR TOWN Mt. Rainier			13d. INSIDE CITY LIM TSP? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 4309 29th St.		
14. FATHER'S NAME First Middle Last Edward J. McCloskey			15. MOTHER'S MAIDEN NAME First Middle Last Marie F. Grunback			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes (If yes give war or dates of service) WWII			16b. SOCIAL SECURITY NO. 216-22-0984		
17. INFORMANT Mrs. Mary A. McCloskey			Address (above address)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 6 hours DUE TO, OR AS A CONSEQUENCE OF (b) Recovering from major surgery DUE TO, OR AS A CONSEQUENCE OF (c) - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION 10/10/68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured appendix			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10/8/68 , 1968, to 10/16/68 , 1968, that (I) yes last saw the deceased alive on 10/15/68 and that in (my) best opinion death occurred on the date and hour and from the causes stated above, (I) did (did not) view the body after death.											
22b. SIGNATURE Dayton O. Watkins			DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 10-16-68					
22d. PHYSICIAN'S NAME (Type) DAYTON O. WATKINS			22e. ADDRESS 5318 Annapolis Rd Gladensbury Md.			23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 11/19/68		
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.			23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.			24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.			25a. REC'D BY REGISTRAR DATE NOV 25 1968		
25b. REGISTRAR'S SIGNATURE Charles Judge			25c. NAME OF CEMETERY OR CREMATORY Mt. Rainier Maryland			25d. LOCATION (City or Town) (County) (State) Mt. Rainier Maryland					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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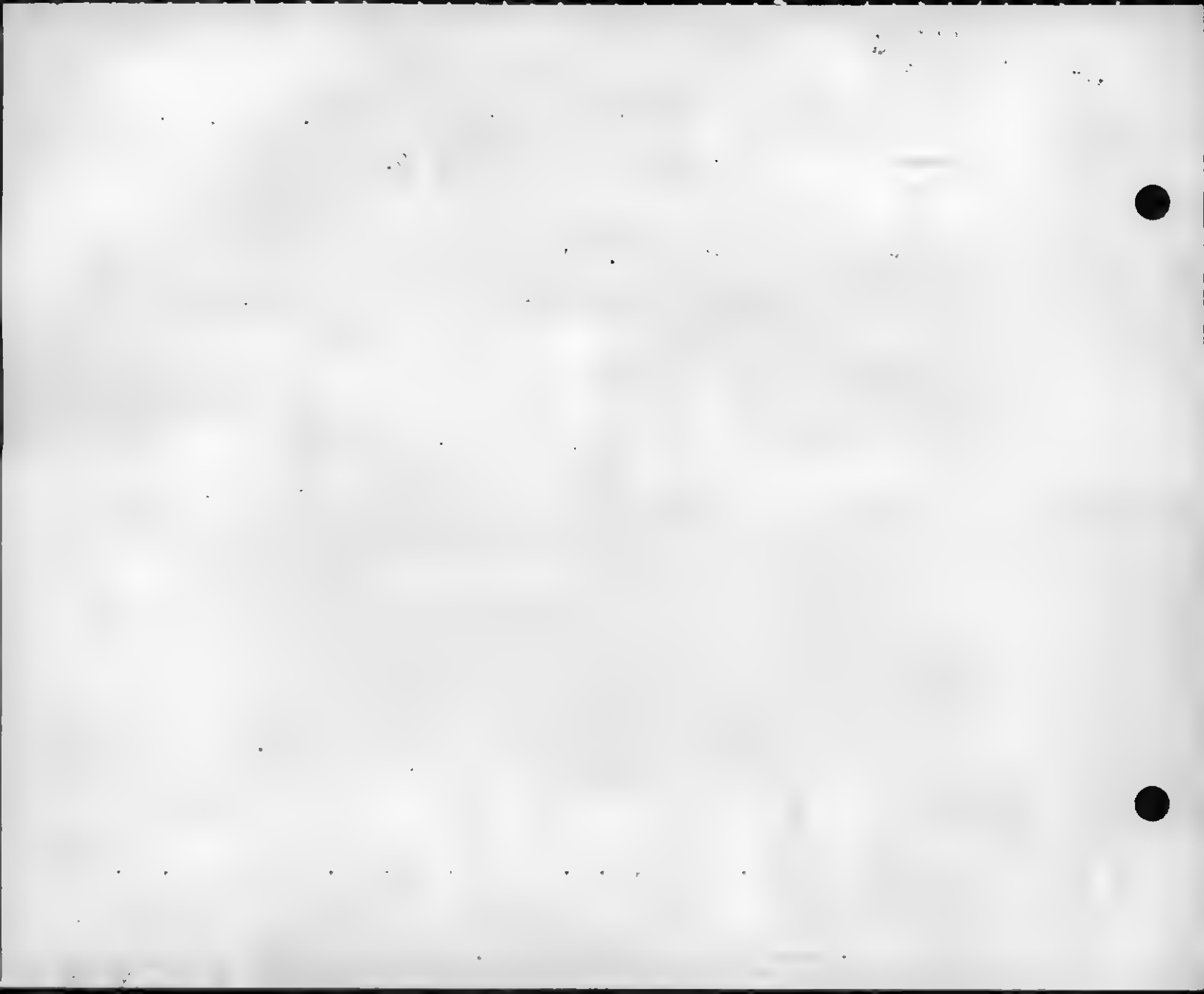
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
John W. McGuire Sr.						11 Month 4, 68		4:55 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
male		White		9/11/12		56 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
Tennessee		U.S.A.				P.G.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Georges Hosp			Photographer		U.S. Govt		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
md			Prince George		Riverdale		YES		5813 Quintana St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
CHARLES WESLEY MCGUIRE			Elizabeth							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No			578-24-3653		Hazel H. McGuire		Riverdale, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) ① Cardiac standstill and cardiogenic shock										
427.5 DUE TO, OR AS A CONSEQUENCE OF										
Card trans, if any, which gave rise to immediate cause (a), stating the underlying cause lost										
(b) Severe electrolyte imbalance										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Malnutrition and dehydration										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
422.1 Impending Delirium Tremens										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
		HOUR A.M. Month Day Year								
		P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town		
22a. I certify that (I) (this hospital) attended the deceased from 10-31, 19-68, to 11-4-1968, that (I) (we) last saw the deceased alive on 11-4-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE			-DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
Riccardo U. FRANCHI								11-4-68		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
			7729 Finn's Lane, Lanham, Md.							
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
Burial		Nov 7, 1968		Cedar Hill Cemetery		Suitland		Pro Geo Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
F. Gasch's Sons			Hyattsville, Md.			DATE NOV 8 1968		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>16388</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>1640</div>									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Ruth Elizabeth McKenney						Nov. 6, 1968			6:15AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 24 HRS
Female		Caucasian		March 29, 1910			58 YRS		MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Washington D C		U S A				Prince George's Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind at work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince Geo. Gen'l Hospital			Packer			Safeway
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY, J.M.T.S? YES <input type="checkbox"/> NO <input type="checkbox"/>
Maryland			Prince George's			Riverdale			5433 55th Place
14. FATHER'S NAME			15. MOTHER'S M.A.D.E.N. NAME						
First Middle Last			First Middle Last						
Richard E Donaldson			Emily H Martin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
no			577 38 1698			Arthur McKenney			Greenbelt, Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>									
4107 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe stenosing coronary arteriosclerosis.</u>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes.		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) this deceased attended the deceased from <u>2/12/1968</u> to <u>Nov. 6, 1968</u> , that (I) was last saw the deceased alive on <u>Sept. 2, 1968</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was <u>did</u> (did not) view the body after death.									
22b. SIGNATURE <u>George J. Hageage</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>11-6-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>George J. Hageage, M. D.</u>						22e. ADDRESS <u>3717 38th Ave., Cottage City, Md. 20722</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov 9, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pro Geo Md.</u>		
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>			25a. REC'D BY REGISTRAR <u>NOV 12 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>



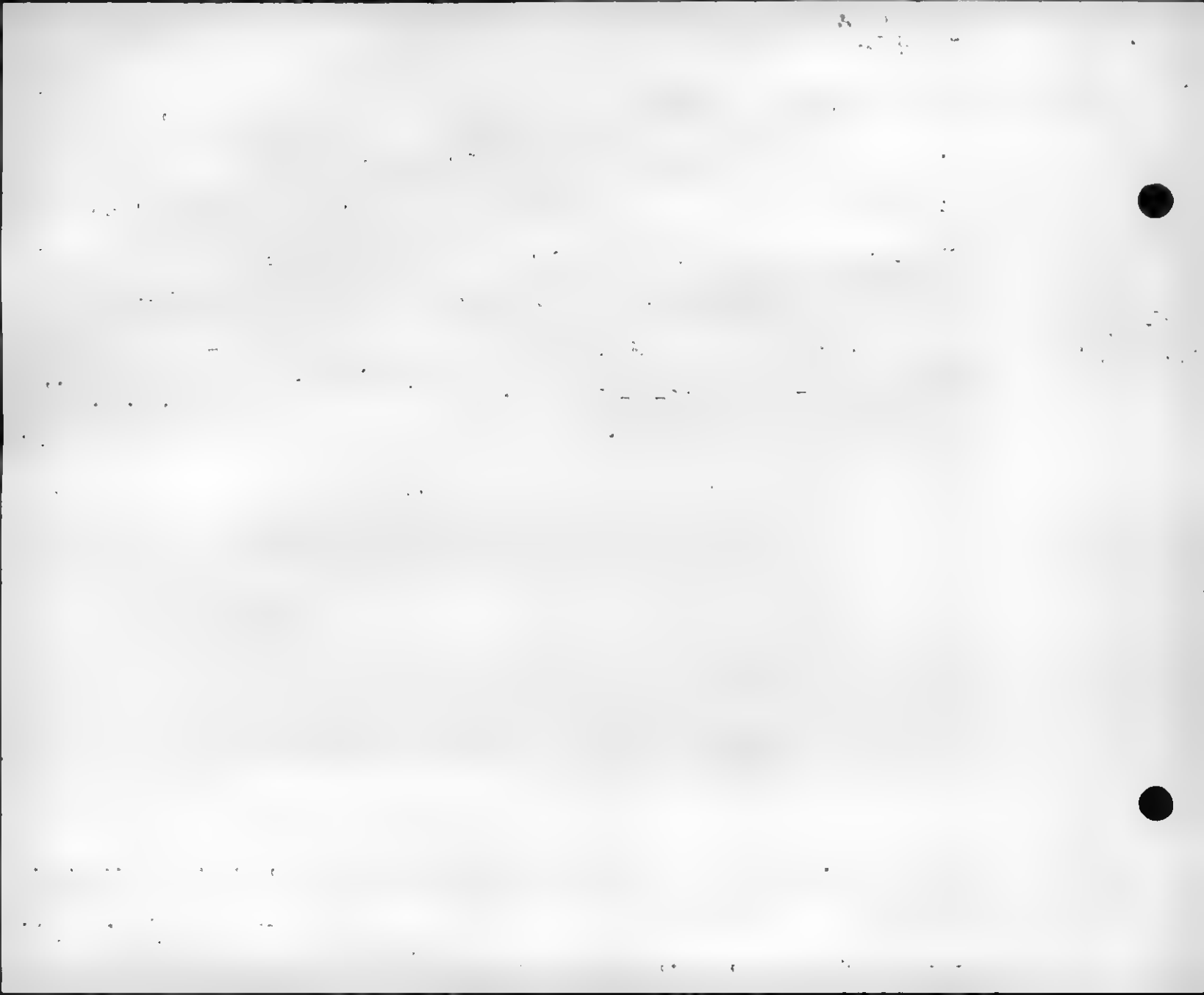
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VR A 1544
30M REV 1-68

16389										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										1040																																																											
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																											
JAMES HORACE MITCHELL										NOVEMBER 23, 1968										9:25 AM																																																											
3 SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS																													
Male										Caucasian										September 9, 1898										70										MONTHS										DAYS										HOURS										MIN									
7a. BIRTHPLACE (State or foreign country)										7b. CIT. ZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																																																	
Tennessee										USA																				Prince Georges County, Md.																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Riverdale										Leland Memorial Hospital										Salesman (retired)																																																											
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LUM. TST. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																																							
Maryland										Prince Georges										Hyattsville										YES										5902 31st Avenue																																							
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last																																																																					
James Mitchell																																																																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																																																	
no										577-30-0929										Sister-in-law Mrs. Clara Mitchell										4801 Connecticut Ave., NW Washington, D. C.																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																											
										Congestive Heart Failure										6 weeks																																																											
										DUE TO, OR AS A CONSEQUENCE OF																																																																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) Hypertensive (arthritis) Renal Disease										5 years																																																											
										DUE TO, OR AS A CONSEQUENCE OF																																																																					
										(c)																																																																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										Vremia																																																																					
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l. med. cal. examiner)										21b. TIME OF INJURY HOUR AM Month Day Year 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																											
22a. I certify that (I) (this hospital) attended the deceased from 1965, to 11/23, 1968, that (I) (we) last saw the deceased alive on 11/9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE P. Colevas										22c. DATE SIGNED 11/24/68																																																											
22d. PHYSICIAN'S NAME (Type) P. Colevas										22e. ADDRESS 3737 Legation St., N. W., Wash., D. C.																																																																					
23a. BURIAL, CREMAT. OR REMOVAL (Specify) Burial										23b. DATE 11/29/68										23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery										23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges, Md.																																																	
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																	
Joseph Gawler's Sons, Inc., Washington, D.C.																				DATE NOV 29 1968										J. Charles Judge																																																	

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. This may be returned for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

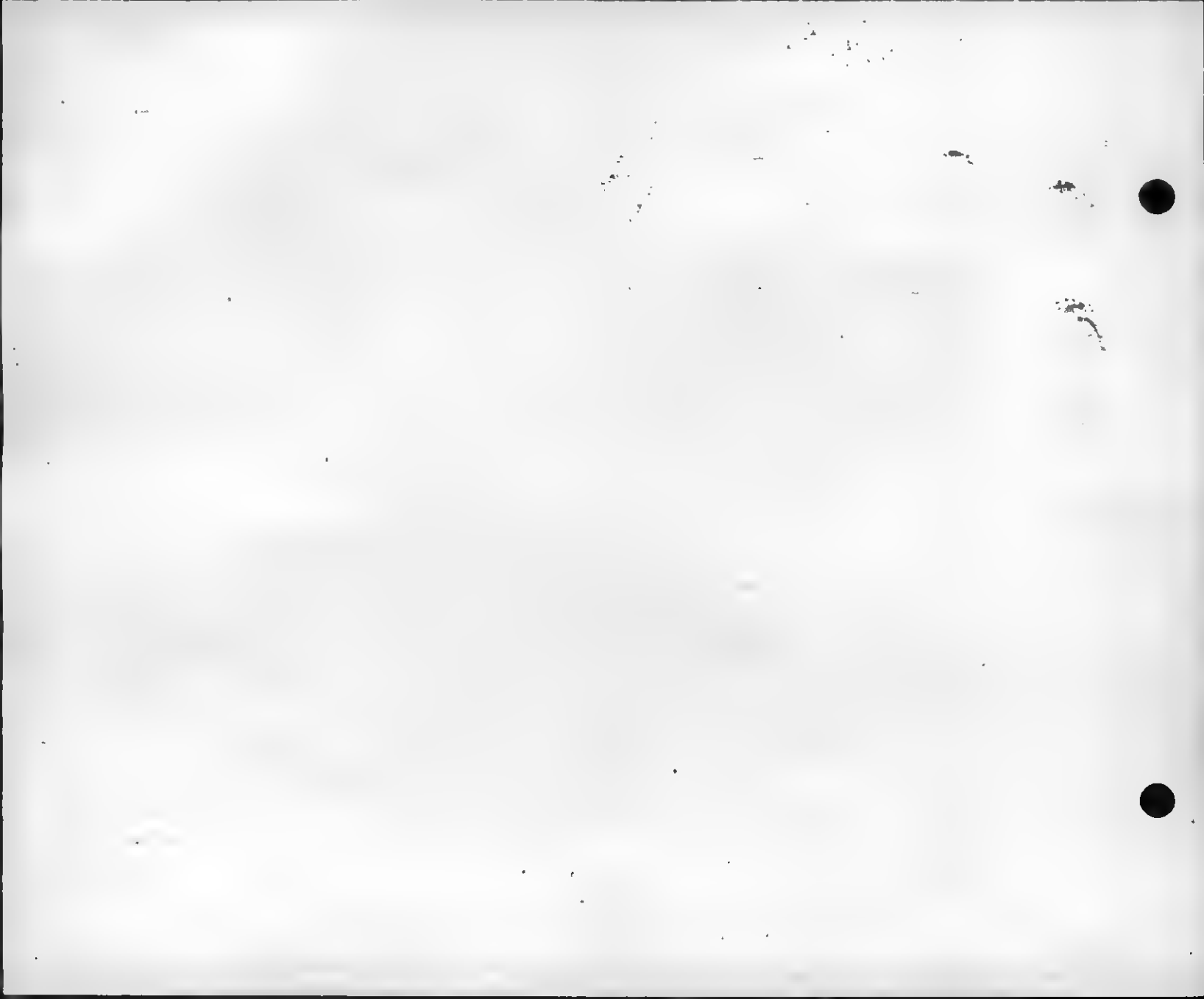
16390

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16404

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 11-19-68 191:10pm				2b HOUR	
Virginia						Montgomery							
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR	
Female	Negro	3-10-1905		63 YRS						11 19 68		191:50pm M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
South Carolina		USA				Prince George's						Md.	
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY	
Cheverly				Prince George Hospital									
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b CITY OR TOWN				13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13d. STREET AND NUMBER	
Maryland				Prince George's Seat Pleasant								403 73rd. Street	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Willie Stewart				Mary McCormick									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17 INFORMANT				ADDRESS	
								Mrs. Rosemary Barnett				403 73rd St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes - over 4 months</u>													
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASS STANT MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED	
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								11-20-68	
John Kehoe MD				Riverdale, Md.				ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, or other disposal (Specify)				23b. DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)	
Burial				11/23/68				Harmony Memorial Park				Maryland	
24 FUNERAL DIRECTOR				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE					
John T. Stewart													
Stewart Funeral Home-4001 Benning Road, N.E.													

NOV 22 1968



**FOR STATE
HEALTH DEPT.**

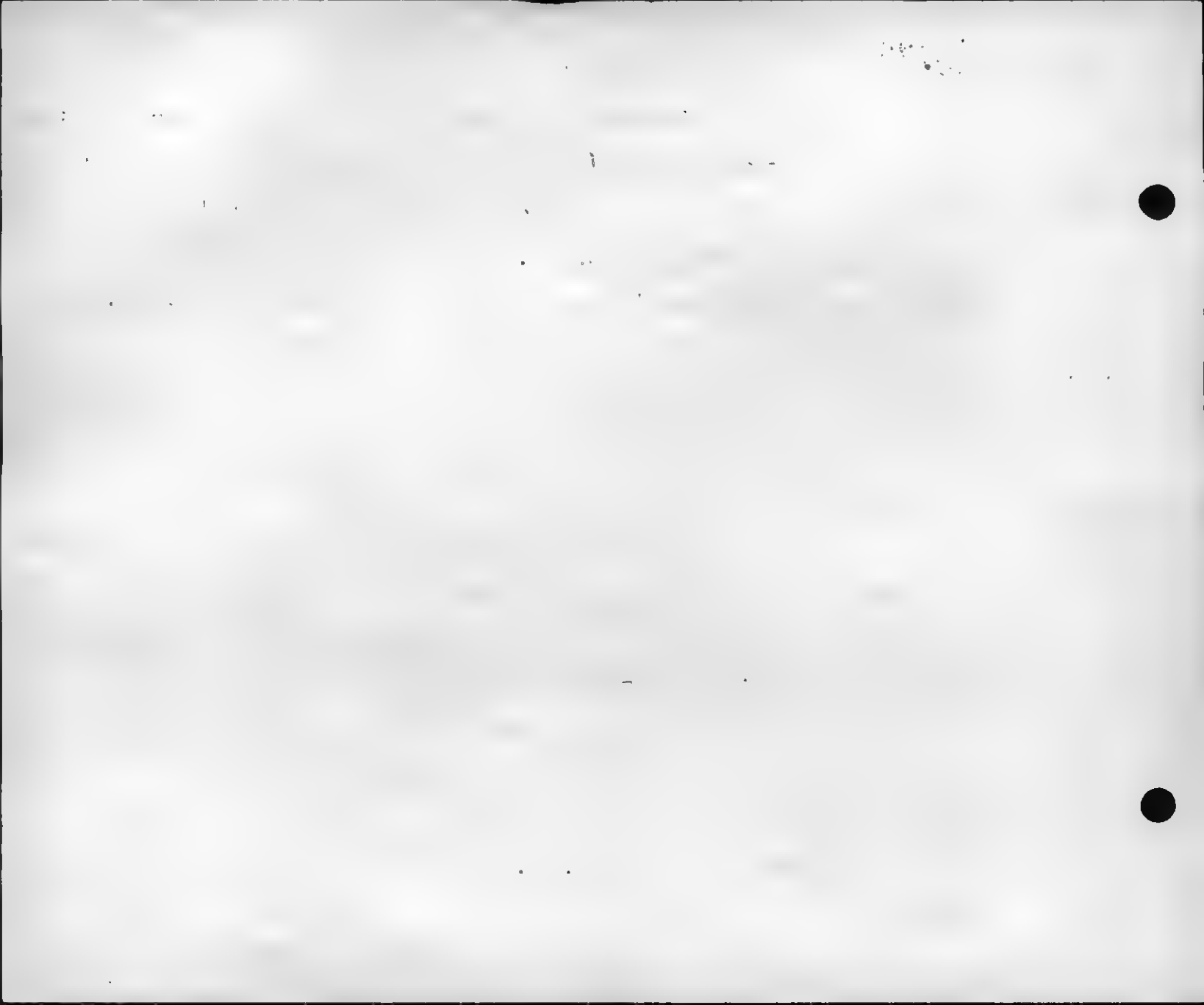
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the PM3 Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 5 Film 06 11/11/68
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16391

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First Middle Last Joan Jeanette Moore			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 11-6-68 19 11:00am			2b. HOUR			
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH 5-28-1936 1937	6. AGE (In years last birthday) 31 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 11 6 68 197:30pm M			2d. HOUR
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md			
10. CITY OR TOWN OF DEATH Seat Pleasant			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7618 F Street, Apt. 203			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. CITY OR TOWN Prince George's Seat Pleasant			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 7618 F Street, Apt. 203
14. FATHER'S NAME First Middle Last Crawley Bryant			15. MOTHER'S MAIDEN NAME First Middle Last Ethel (unknown)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT ADDRESS George Moore 201 Elmira St., S.W.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 7-5 DUE TO, OR AS A CONSEQUENCE OF <u>Hanging</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 974X									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 11:00am 11-6-1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Hung self at home			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home			21f. LOCATION Street or R.F.D. No. City or Town County State same as #13			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED 11-7-68			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 11/10/68			23c. NAME OF CEMETERY OR CREMATORY Carver Cemetery			23d. LOCATION (City or Town) (County) (State) Suffolk, Virginia
24. FUNERAL DIRECTOR Stewart Funeral Home			ADDRESS 4001 Benning Road, N.E.			25a. REC'D BY REGISTRAR NOV 12 1968			25b. REGISTRAR'S SIGNATURE f Charles Judge



16392

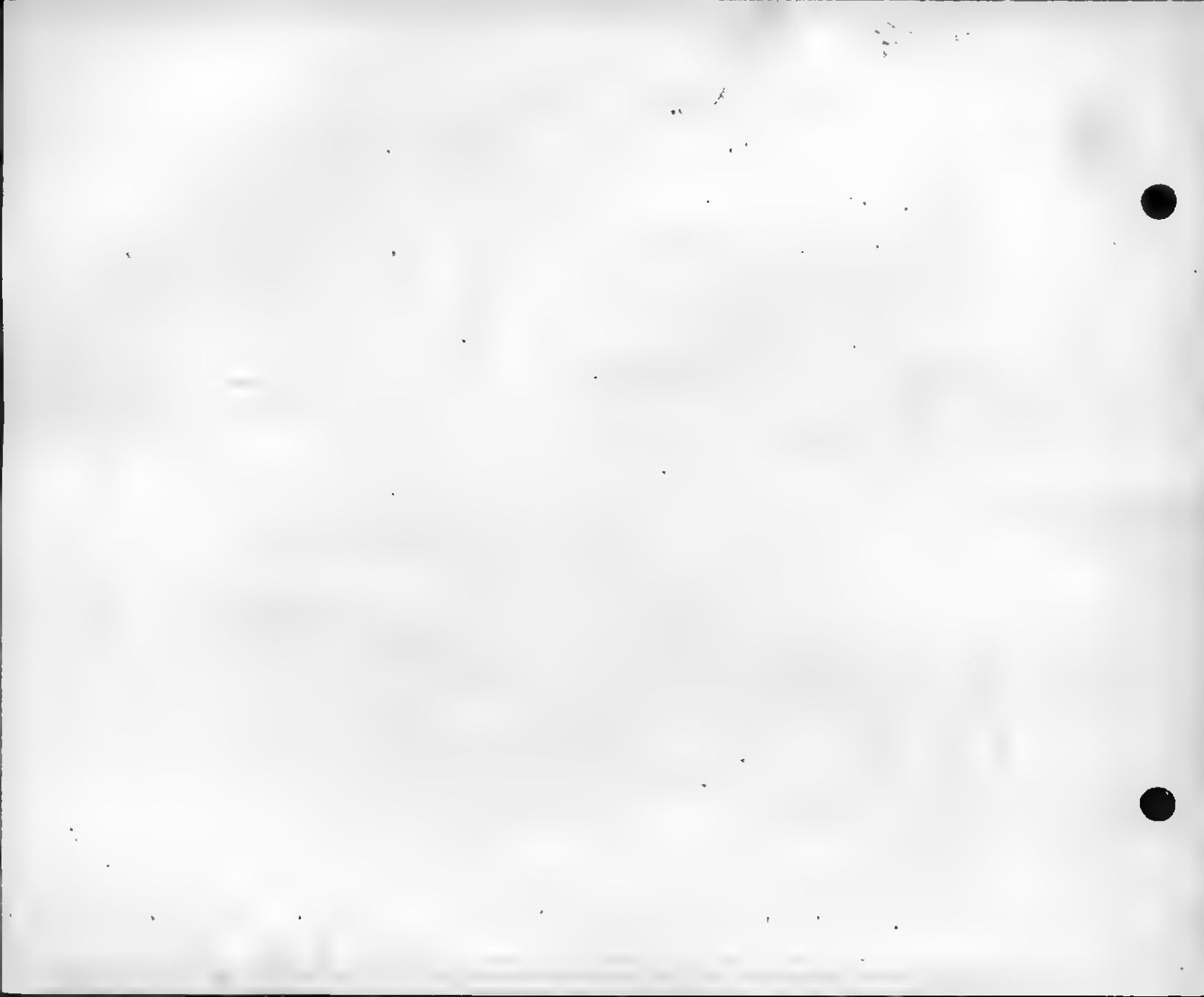
CERTIFICATE OF DEATH

16466

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
Max		C.		Moureaux	Nov 4, 1968			
3 SEX male		4 RACE white		5. DATE OF BIRTH July 4, 1892		6 AGE (In years last birthday) 76 YRS.		IF UNDER YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md		
10. CITY OR TOWN OF DEATH Hyattsville,		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address) 3919 River st		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Machinist		12b. KIND OF BUSINESS OR INDUSTRY U S Government		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md		13b. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3919 Oliver St		
14. FATHER'S NAME First Middle Last Max F Moureaux		15 MOTHER'S MAIDEN NAME First Middle Last Mary B Binger						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <input checked="" type="checkbox"/> No		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 579 40 0456		17. INFORMANT Mable Moureaux Address Hyattsville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased, from <u>Nov 11-4</u> , 19 <u>68</u> , to <u>11-4</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>A Deitz</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>11-5-68</u>		
22d. PHYSICIAN'S NAME (Type) A Deitz		22e. ADDRESS Pro Geo Plaza		Hyattsville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 7, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.		
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 8 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 28 Film 408 1/8 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
16398 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10401

1. DECEASED NAME (Type or Print) Jean Wedle Murphy			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 11-17-68 19 10:15am			2b. HOUR		
3 SEX Female	4 RACE White	5. DATE OF BIRTH 5-30-1934	6 AGE (n years lost birthday) 34 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 11 Day 17 Year 68 19 10:55am		
7a. BIRTHPLACE (State or foreign country) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp ital give street address) Ieland Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before 13c. CITY OR TOWN admission) STATE Maryland Prince George's Beltsville		13b. COUNTY		3d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET AND NUMBER 4305 Birmingham Place		
14. FATHER'S NAME First Middle Last Rupert C Weddle			15. MOTHER'S MAIDEN NAME First Middle Last Laura Jane Price					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Charles Murphy - Abalone			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute viral myocarditis DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) +3IX 2 months pregnancy								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John Kehoe			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 11-18-68		
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11-21-68		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cem		23d. LOCATION (City or Town) (County) (State) Liberty Kentucky		
24. FUNERAL DIRECTOR Harold Dean Pomeroy				ADDRESS Home, Ray...		25a. REC'D BY REGISTRAR NOV 25 1968		25b. REGISTRAR'S SIGNATURE ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

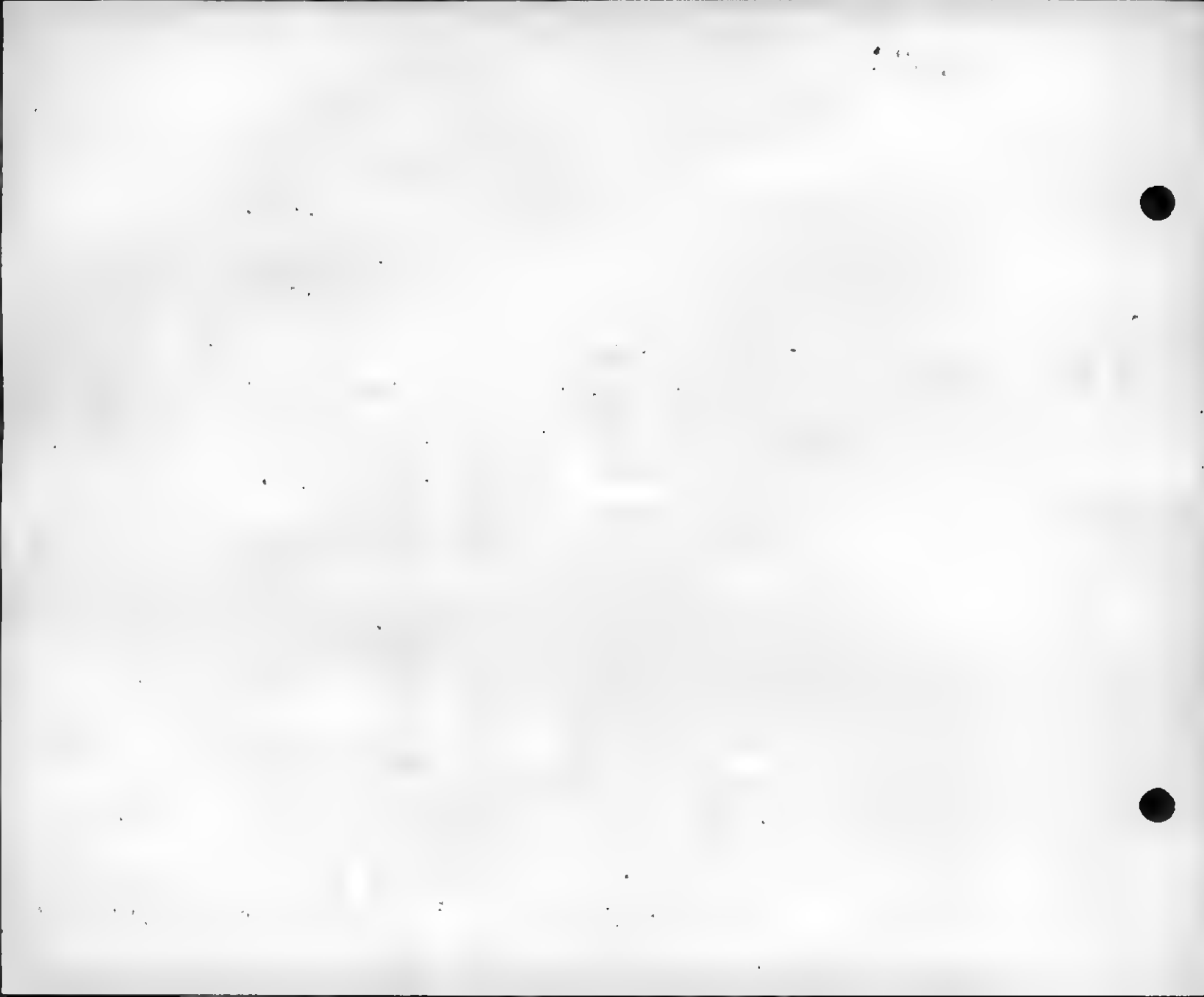
16394

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Raymond T. Nair			2a. DATE OF DEATH 11- Month 14- Day 68 Year			2b. HOUR 9:45aM	
3 SEX Male		4. RACE White		5. DATE OF BIRTH 3-1-09		6 AGE (in years lost birthday) 59 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 4002 Oliver St.,		14. FATHER'S NAME First Middle Last Franklin Nair		15. MOTHER'S MAIDEN NAME First Middle Last Mary SUSAN Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 225124850		17 INFORMANT Spouse and Medical Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4124 VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC C-V DISEASE (c) UNKNOWN PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2 FEB, 1965, to 14 NOV, 1968, that (I) (we) last saw the deceased alive on 14 NOV, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE (C.) - Houmann				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 14-NOV 1968	
22d. PHYSICIAN'S NAME (Type) C. J. Houmann, M.D.				22e. ADDRESS 4408 Queensbury Rd., Riverdale, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE NOV. 16, 1968		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.		23d. LOCATION (City or Town) (County) (State) COLMAR MANOR MARYLAND	
24. FUNERAL DIRECTOR W. W. CHAMBERS Co. RIVERDALE, Md.				25a. RECD BY REGISTRAR DATE NOV 18 1968		25b. REGISTRAR'S SIGNATURE John J. Jones	

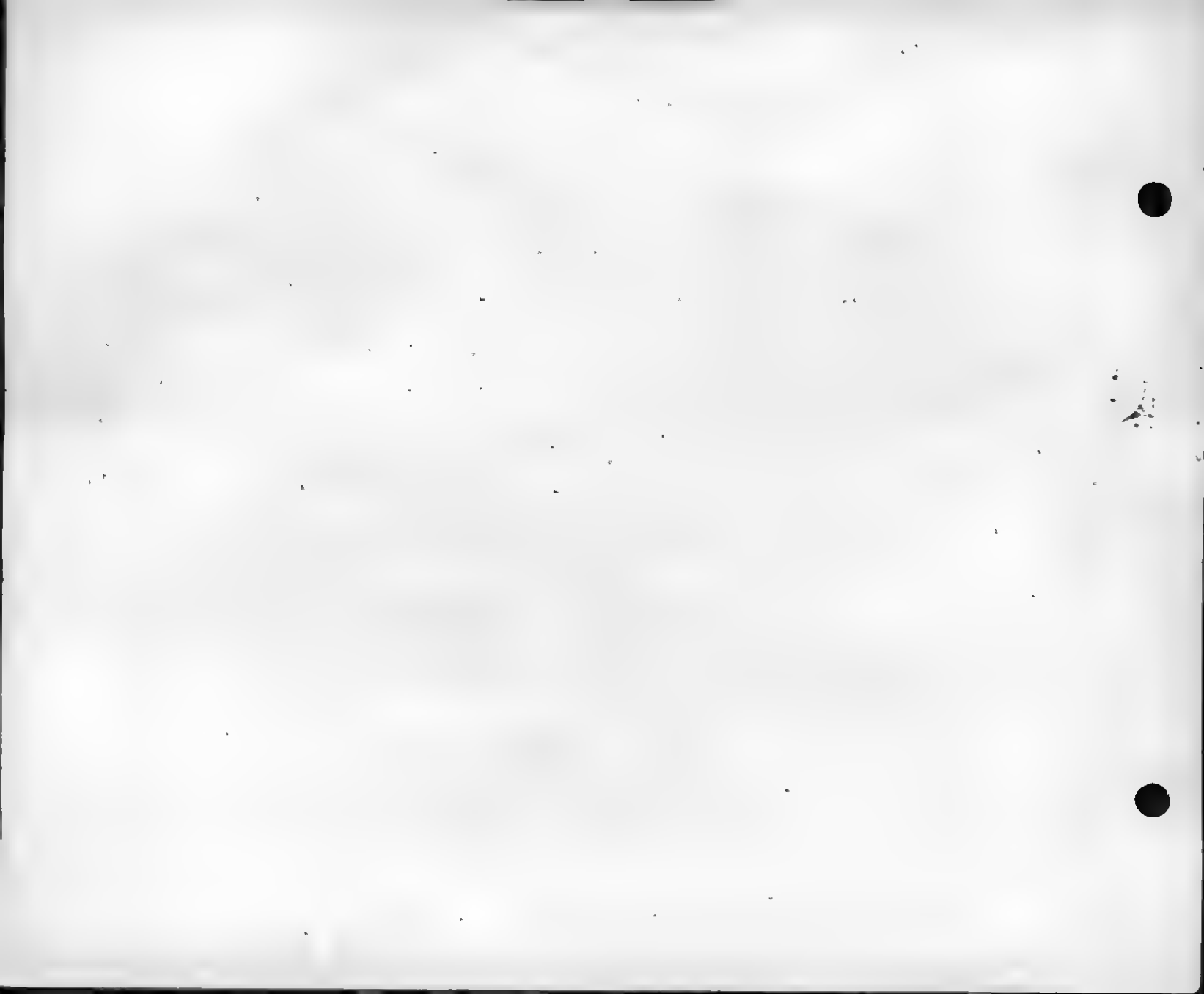
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
16395										
CERTIFICATE OF DEATH										
16409										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Olga			M. Nelson			Nov Month 12 Day 1968		11:15 P.M.		
3 SEX		4 RACE		5 DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		
Female		White		1-16-1898		70 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Minnesota		U S A				Pr. Geo. Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Oxon Hill			5634 Fargo Ave.			housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Pr. Geo.		Oxon Hill		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5634 Fargo Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Michael			Fricker			unknown Meyer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No					Clarine Penewell		5634 Fargo Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4407 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19 yrs 20 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21a. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from Jan 1967, to Nov 12, 1968, that (I) (we) last saw the deceased alive on 11/19/68, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Eugene J. Gaby MD DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 11/14/68										
22d. PHYSICIAN'S NAME (Type) E. J. Gaby MD 22e. ADDRESS 1704 Riviera St Annapolis Md										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
Burial		11-15-68		Arlington National Cem.		Arlington		Va.		
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. S. E. Suitland, Md.					25a. REC'D BY REGISTRAR DATE NOV 20 1968		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16396

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16400

1. DECEASED NAME (Type or print) First Middle Last Mary (NMI) Noteware			2a. DATE OF DEATH Month 11 Day 15 Year 68 2b. HOUR 550P M		
3 SEX Female	4 RACE White	5. DATE OF BIRTH 15 Nov 1968		6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges County Md		
10. CITY OR TOWN OF DEATH Andrews AFB	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Infant	12b. KIND OF BUSINESS OR INDUSTRY Infant	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY Prince Georges	13c. CITY OR TOWN District Hgts	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2084 Addison Rd, Apt 1	
14. FATHER'S NAME First Middle Last Carson W Noteware			15. MOTHER'S MAIDEN NAME First Middle Last Carol L Hansen		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT Address Father 2084 Addison Rd, District Hgts	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7762 <i>Cardiac arrest - respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Resp arrest</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 15 Nov, 1968, to 15 Nov, 1968, that (I) (we) last saw the deceased alive on 15 Nov, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (d did not) view the body after death.					
22b. SIGNATURE <i>James E Willard</i>			DEGREE	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 15 Nov 68
22d. PHYSICIAN'S NAME (Type) James E Willard			22e. ADDRESS Malcolm Grow USAF Hospital		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-21-68	23c. NAME OF CEMETERY OR CREMATORY Tulsa Cemetery		23d. LOCATION (City or Town) (County) (State) Tulsa Oklahoma	
24. FUNERAL DIRECTOR W. W. Chambers		ADDRESS 517 N. SE.		25a. REGD BY REGISTRAR DATE Nov 21 1968	25b. REGISTRAR'S SIGNATURE <i>Walter Chambers</i>



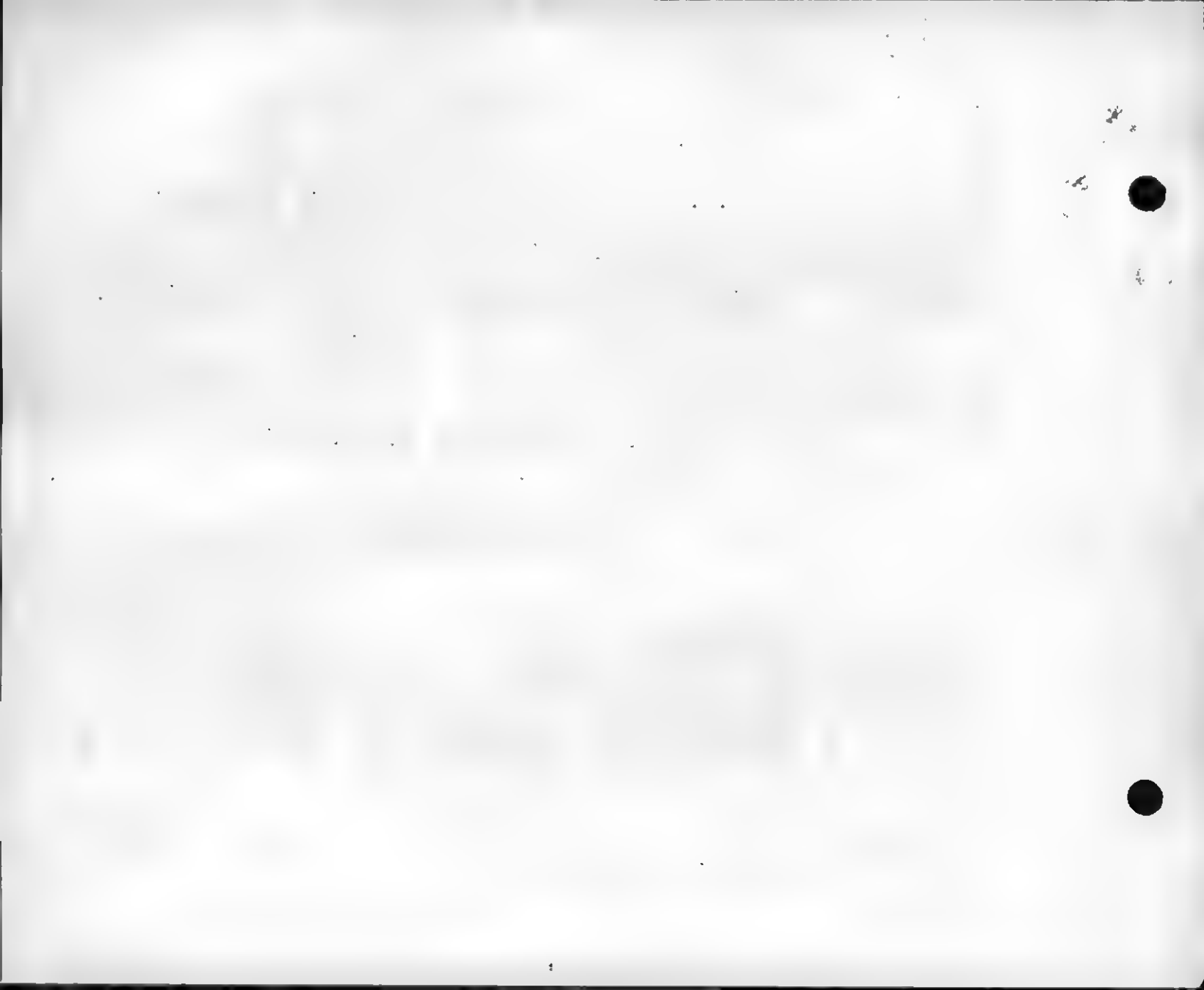
16397

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) SUSIE		First C		Middle C		Last NOWOSACKI		2a. DATE OF DEATH NOV Month 18 Day 1968		2b. HOUR 2215 M	
3 SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 25 Oct 1921		6. AGE (In years last birthday) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 MRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Alabama		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md					
10. CITY OR TOWN OF DEATH Andrews AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov.					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Prince Georges Oxon Hill		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER 4401 Eugenia St.			
14. FATHER'S NAME First Sam		Middle Carruba		Last Susie		15. MOTHER'S MAIDEN NAME First C		Middle ?		Last ?	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 423140771		17. INFORMANT Address Husband Same as item # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Metastases and Insufficiency 1621 DUE TO, OR AS A CONSEQUENCE OF (b) Oat Cell carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (c) 11 weeks										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1621											
9a. DATE OF OPERATION 17 Sep 68		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hepatomegaly		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that he (this hospital) attended the deceased from 30 Oct , 19 68 , to 18 Nov , 19 68 , that he (we) last saw the deceased alive on 18 Nov , 19 68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (we) did (did not) view the body after death.											
22b. SIGNATURE <i>David S Rosenthal</i>		DEGREE		ATTENDING PHYS <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 18 Nov 68	
22d. PHYSICIAN'S DAVID S ROSENTHAL, MAJ USAF MC		22e. ADDRESS MALCOLM GROW USAF HOSP ANDREWS AFB									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-22-68		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) Arlington		(County)		(State) Va.	
24. FUNERAL DIRECTOR Wilhelm Funeral Home		ADDRESS 4308 Suitland Rd.		25a. RECEIVED BY REGISTRAR NOV 25 1968		DATE		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

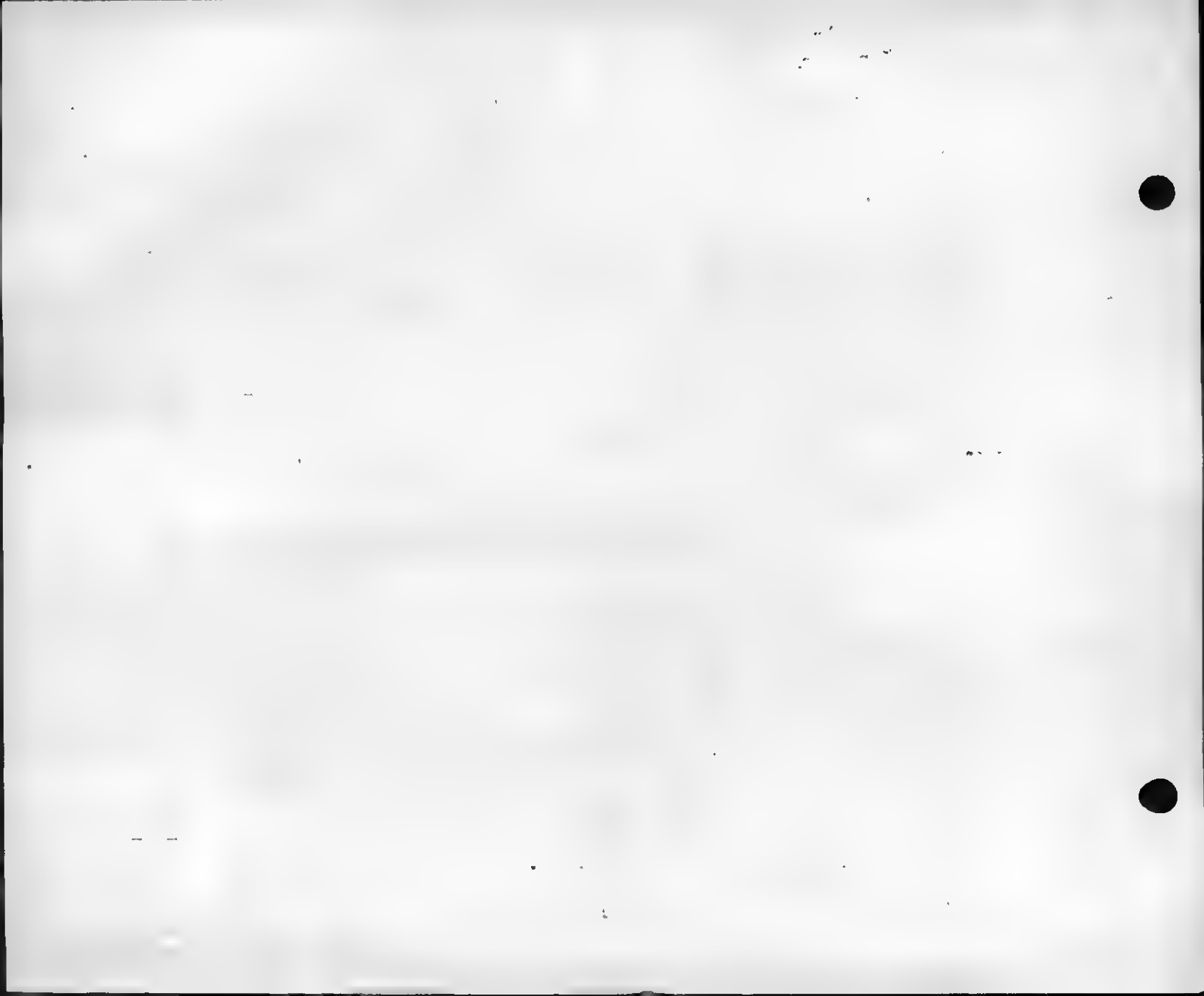
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16393

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

104

1 DECEASED NAME (Type or Print) Michael Edward O'Connor			2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> 11 Day 24 Year 68 196:05am			2b HOUR		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 8-3-1908	6 AGE (in years last birthday) 60 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month 11 Day 24 Year 68 196:05am		
7a BIRTH-PLACE (State or foreign country) W. Va.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md.		
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) Prince George Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Electrician		12b KIND OF BUSINESS OR INDUSTRY -
13a USUAL RESIDENCE (Where deceased lived, institution, residence before death) STATE Maryland COUNTY Prince George's			13c CITY OR TOWN Bowie		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 15616 Old Chapel Road		
14 FATHER'S NAME First Martin Middle O'Connor Last O'Connor			15. MOTHER'S MAIDEN NAME First Ellen Middle Carr Last Carr					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO -		17. INFORMANT Carmen K. O'Connor ADDRESS 3511 - Doverport St., Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) - DUE TO, OR AS A CONSEQUENCE OF (c) - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH over 5 yrs.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a DATE OF OPERATION -			19b CONDITION FOR WHICH OPERATION WAS PERFORMED? -			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John Kehoe MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 11-25-68		
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) -		
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE 11/27/68		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d LOCATION (City or Town) (County) (State) Colmar Manor, Md.		
24 FUNERAL DIRECTOR Valley's Funeral Home, Inc.				ADDRESS 111 Rainier Rd., Maryland		25 REC'D BY REG STRAR NOV 29 1968		25b REG STRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 8 Film 0407 12/3/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13415

16399

CERTIFICATE OF DEATH

DECEASED NAME (Type or print) <i>Mary</i>		First <i>E.</i>	Middle <i>O'Donnell</i>	Last	2a DATE OF DEATH Month <i>Nov.</i> Day <i>25</i> Year <i>1968</i>	2b HOUR <i>6:45 PM</i>
3. SEX <i>Female</i>	4 RACE <i>W</i>	5. DATE OF BIRTH <i>2/22/96</i>		6. AGE (In years last birthday) <i>72</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN	
7a. BIRTHPLACE (State or foreign country) <i>DC.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Prince Georges</i>		Md	
10 CITY OR TOWN OF DEATH <i>Forestville.</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>The Regent Rehab. Center.</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>refused</i>	12b KIND OF BUSINESS OR INDUSTRY <i>W.S. & Co.</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>md.</i>	13b COUNTY <i>prince georges</i>	13c CITY OR TOWN <i>Croft Hill</i>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>1921 Owens Road.</i>		
14. FATHER'S NAME First <i>Patrick</i> Middle <i>O'Donnell</i> Last	15. MOTHER'S MAIDEN NAME First <i>Eunice</i> Middle <i>Boyle</i> Last		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			
16b SOCIAL SECURITY NO		17 INFORMANT <i>Eunice Ganga-254-Pedra lane Va.</i>		Address <i>Therma</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory arrest</i> <i>41</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>A.S.H.C.V.D. and extensive CVA</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i> <i>5 mos</i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <i>41-2</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State		
22a I certify that (I) (this hospital) attended the deceased from <i>July</i> , 1968, to <i>Nov. 25</i> , 1968, that (I) (we) last saw the deceased alive on <i>Nov. 18</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death						
22b. SIGNATURE <i>F. Joseph Weber (Sealing, M.D.)</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11-25-68</i>
22d. PHYSICIAN'S NAME (Type) <i>F. JOSEPH WEBER</i>		22e. ADDRESS <i>3230 Penna Ave. S.E.</i>				
23a. BURIAL CREMATION, REMOVAL (Type) <i>Burial</i>	23b. DATE <i>Nov. 27-68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ceadr Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>		
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>		ADDRESS <i>1661-Gd. Hope Rd. SE</i>		25a. REC'D BY REGISTRAR <i>Wash., DC</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



16400

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) SEIKO		First Middle Last PALUBINSKY		2a DATE OF DEATH November 2 Day 1968 Year		2b. HOUR 9:22 PM	
3 SEX FEMALE		4. RACE MONGOLIAN		5. DATE OF BIRTH 22 FEB 1926		6. AGE (In years last birthday) 42 YRS.	
7a BIRTHPLACE (State or foreign country) JAPAN		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE'S Md.	
1d. CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAF HOSP		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived; if institution, Residence before admission) DELAWARE		13c CITY OR TOWN DOVER AFB		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1033 C, 2nd AVE.	
14 FATHER'S NAME TOSHIKO		First Middle Last SAITO		15 MOTHER'S MAIDEN NAME First Middle Last YOSHIKO SHIBUE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No or unknown		16b SOCIAL SECURITY NO		17 INFORMANT HUSBAND SAME AS # 13		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Metastatic carcinoma cervix</i> 180X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>14 OCT</u> , 19 <u>68</u> , to <u>2 NOV</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2 NOV</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Cecil E. White M.D.</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED 2 NOV 68	
22d PHYSICIAN'S NAME (Type) CECIL E. WHITE, MAJ, USAF, MC				22e ADDRESS MALCOLM GROW USAF HOSPITAL ANDREWS AFB, WASH, D.C. 20331			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 11-5-68		23c NAME OF CEMETERY OR CREMATORY Removed by Oravitz & Sons		23d LOCATION (City or Town) (County) (State) Shenandoah, Penna.	
24 FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. S. E.				25a REC'D BY REGISTRAR DATE NOV 6 1968		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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NOTIFICATION 18 JUL 2003

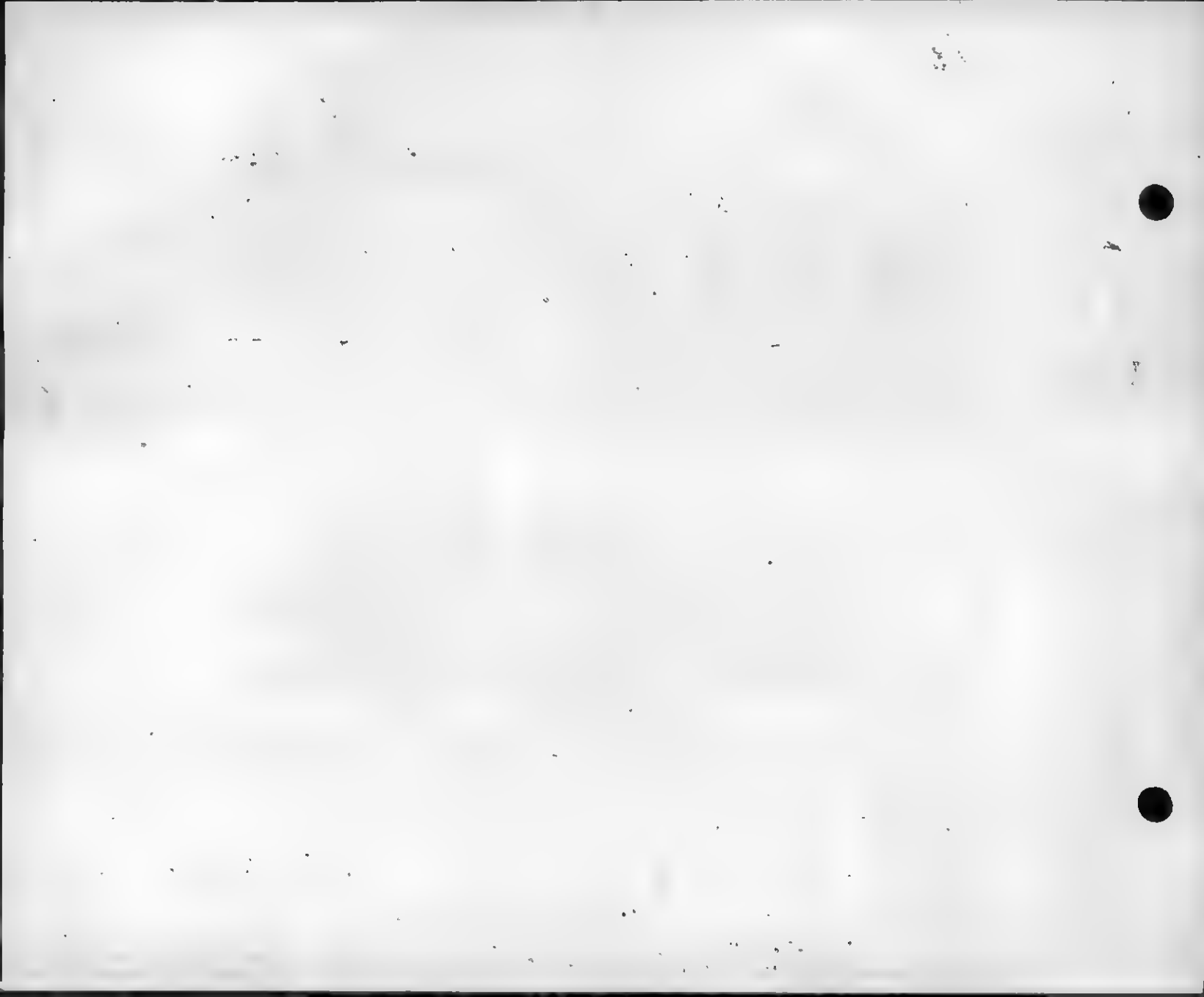
<div style="display: flex; justify-content: space-between;"> 16401 MARYLAND STATE DEPARTMENT OF HEALTH 16415 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Anna			Paulkovich			Nov. Month 20, Day 1968 Year			9:15PM		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		Caucasian		10/2/1881			87 YRS				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Austria		U S A				Prince George's			Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of work ing life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Geo. Gen'l Hospital			Housewife			Home		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Prince George's		Lanham				6601 Oak Lane		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
Mike Stanasic			Barbara Zilich								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT			Address			
no					John Paulkovich			Lanham, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory distress</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic broncho pulmonary disease</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>Arteriosclerotic heart disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from <u>10-19</u> , 19 <u>68</u> , to <u>11-20</u> , 19 <u>68</u> , that (I) did saw the deceased alive on <u>11-20</u> , 19 <u>68</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.											
22b. SIGNATURE <u>Fidel J. Quintana</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED <u>11-21-68</u>			
22d PHYSICIAN'S NAME (Type) <u>FIDEL J. QUINTANA</u>				22e. ADDRESS <u>8715 FIRST AVE, SPRING, MD.</u>							
23a BURIAL, CREMATON, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial		11/23/68		Parklawn Cemetery			Rockville Montgomery Md.				
24 FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REG. SEAR		25b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons				Hyattsville, Md.				NOV 25 1968			



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16402											
Items 6 Film G 407 12/6/68 11w											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <i>Stella May Plummer</i>			First Middle Last			2a DATE OF DEATH <i>Nov</i> Month <i>24</i> Day <i>1968</i> Year			2b HOUR <i>10 A M</i>		
3 SEX <i>Female</i>			4 RACE <i>White</i>			5 DATE OF BIRTH <i>5/27/89</i>			6 AGE (In years last birthday) <i>79</i> YRS		
7b BIRTHPLACE (State or foreign country) <i>Virginia</i>			7c CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Pr. Georges</i> Md		
10 CITY OR TOWN OF DEATH <i>Laurel</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>16112 Laurel Ridge Dr.</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md.</i>			13b COUNTY <i>Pr. Geo.</i>			13c CITY OR TOWN <i>Laurel</i>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e STREET AND NUMBER <i>16112 Laurel Ridge Dr</i>			14 FATHER'S NAME First Middle Last <i>Alfred -- Conner</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Elizabeth --- Mary</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>		
16b SOCIAL SECURITY NO <i>None</i>			17. INFORMANT <i>Mrs. Jean Pavez</i>			Address <i>16112 Laurel Ridge Dr</i>			18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>			DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>OWK.</i>					
4359			DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF								
			DUE TO, OR AS A CONSEQUENCE OF								
			DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Oct 4, 1968, to Nov 27, 1968, that (I) (we) last saw the deceased alive on Nov 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>Robert S. McCeney</i>			DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED <i>11/27/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Robert S. McCeney</i>			22e ADDRESS <i>402 Main St. Laurel, Md.</i>								
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b DATE <i>11-27-1968</i>			23c NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem.</i>			23d LOCATION (City or Town) (County) (State) <i>Arlington, Virginia</i>		
24. FUNERAL DIRECTOR <i>Warner E. Humphrey, Inc.</i>			ADDRESS <i>Sil. Spr. Md.</i>			25a REC'D BY REGISTRAR <i>NOV 29 1968</i>			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



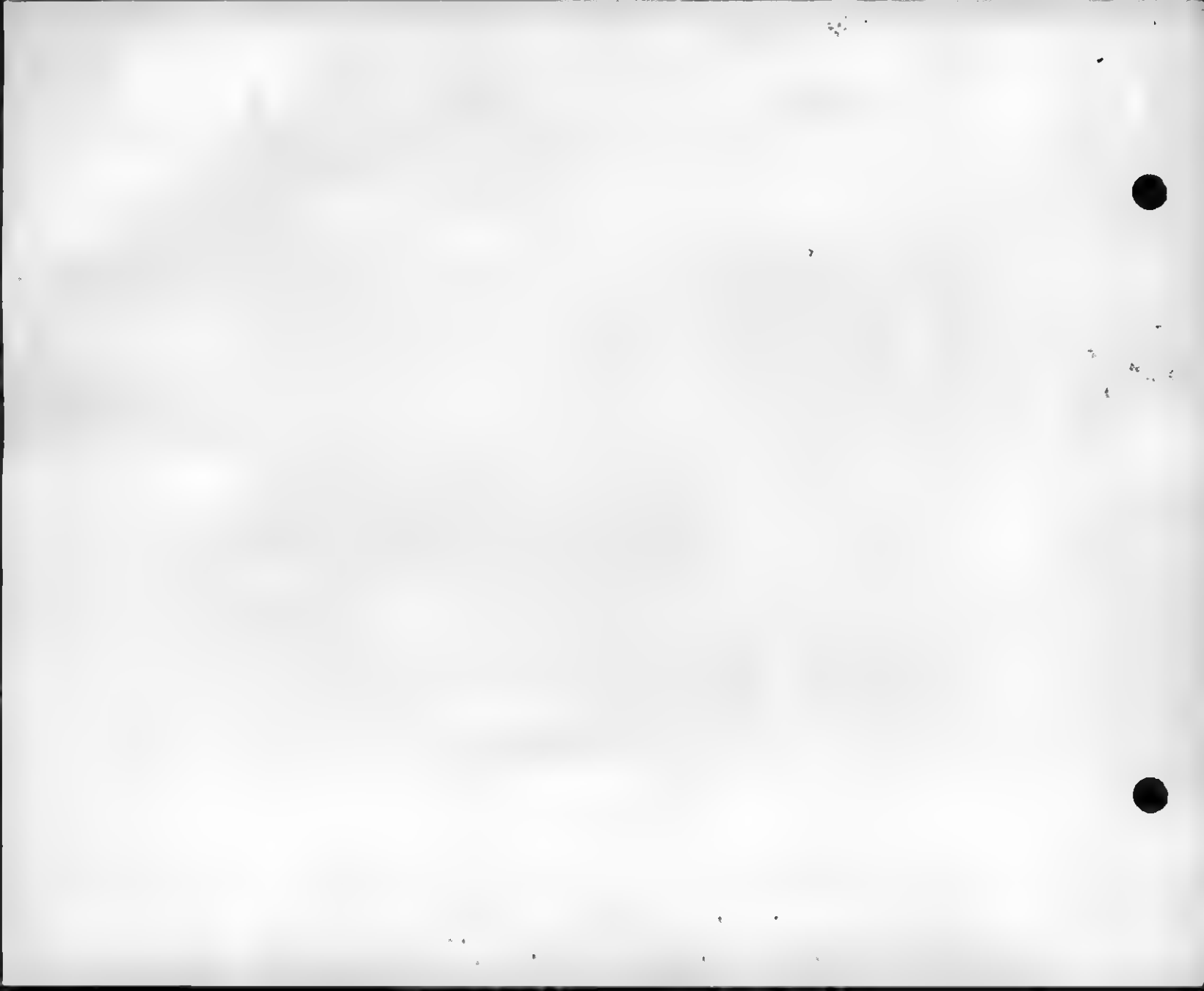
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16402 Frederick

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Frederick B. Potts		2a. DATE OF DEATH Month 11 Day 22 Year 68		2b. HOUR 7:30 PM
3. SEX male	4. RACE white	5. DATE OF BIRTH April 5-1886		6. AGE (In years last birthday) 82 YRS
7a. BIRTHPLACE (State or foreign country) Pa		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH pr. georges Md
10. CITY OR TOWN OF DEATH Forestville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Regent nursing home		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) last many yrs
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE md		13b. COUNTY pr georg	13c. CITY OR TOWN Forestville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First William a. Middle potts Last anna		15. MOTHER'S MAIDEN NAME First anna Middle brant Last brant		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 20		17. INFORMANT James M. Powell - 7304 - Justice St. Address ST
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 10 yrs. Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (H) (this hospital) attended the deceased from July 6 , 19 66 , to 11-22 , 19 68 , that (H) (we) last saw the deceased alive on 11-22 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.				
22b. SIGNATURE W.B. Sheer M.D.		22c. DATE SIGNED 11-22-68		22d. PHYSICIAN'S NAME (Type) WALTER B. SHEER
22e. ADDRESS 6400 MARLBOROUGH PIKE S.E. WASH. D.C.		22f. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 26, 68	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR Simmons Bros.		25a. REC'D BY REGISTRAR DATE NOV 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

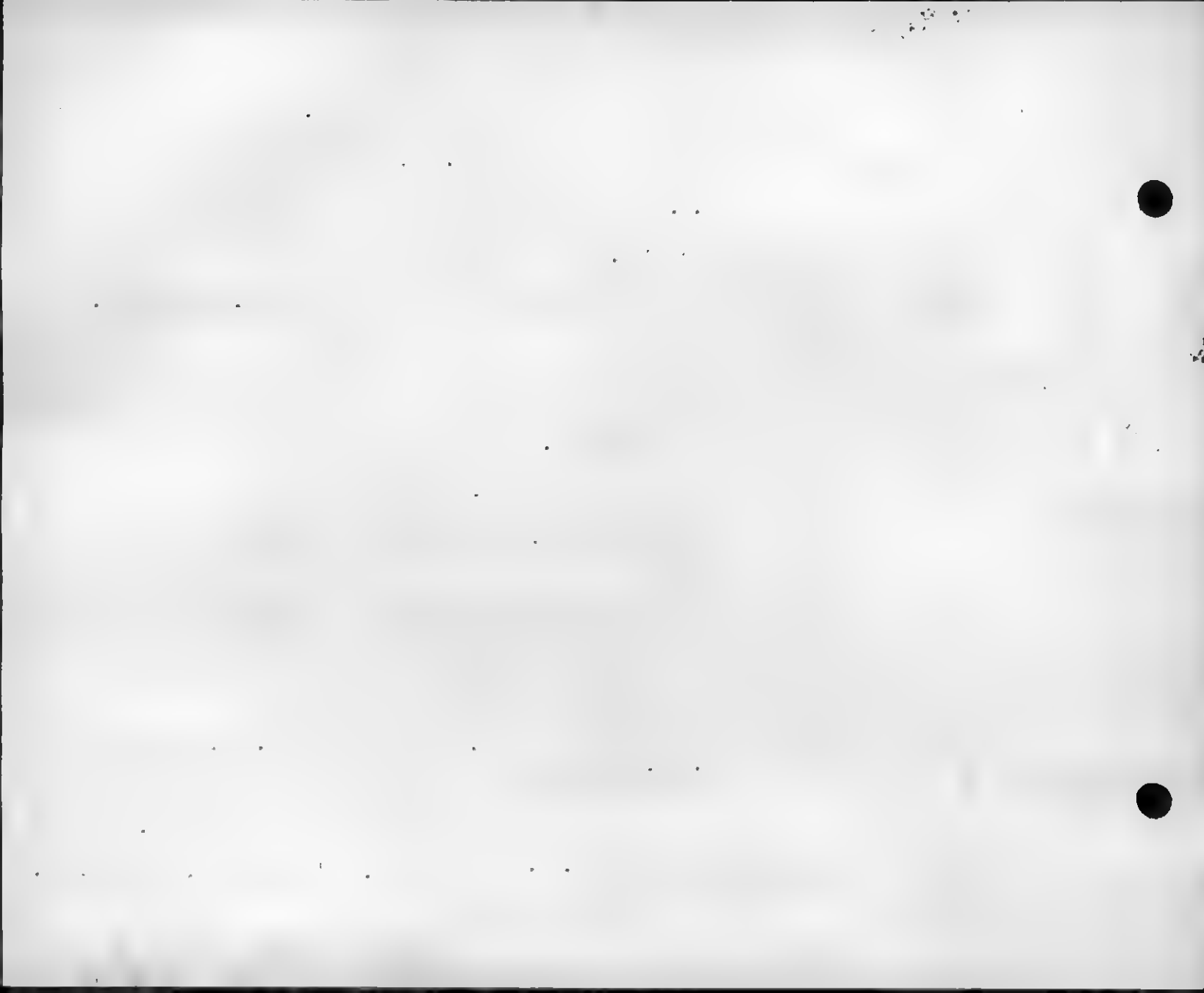


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VR A15 (4)
45M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
16404 Items # 14 & 15 taken from birth cert. 2770/68 ver. 1041												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
Jerome Anthony Proctor						Nov. 24, 1968			4:30 PM			
3 SEX		4. RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Negroid		Sept. 26, 1968			YRS		MONTHS 2 DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Md.		U.S.A.				Prince George's			Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind at work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince Geo. Gen'l Hospital									
13a. U.S.A. RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Maryland			Prince George's			Oxon Hill			6309 St. Barnbas Rd.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
Sidney Joseph Proctor			Mary Louise Simms									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u>												
7769 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
(b) <u>Atelectasis of Lungs.</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(c) <u>Pulmonary Edema.</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)								
		HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION		Street or R.F.D. No		City or Town		County State		
22a. I certify that the (this hospital) attended the deceased from <u>Nov. 21, 1968</u> , to <u>Nov. 24, 1968</u> , that we (we) last saw the deceased alive on <u>Nov. 24, 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above we (we) did not view the body after death.												
22b SIGNATURE						DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED		
										Nov. 25, 1968		
22d PHYSICIAN'S NAME (Type)						22e. ADDRESS						
Bernardo Alvarado, M. D.						Prince Geo. Gen'l Hospital, Cheverly, MD.						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)		
		11/27/68		St. Paul Methodist		Oxon Hill, Md.						
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
ROBERT G. MASON FUNERAL HOME, INC.						DEC 2 1968		Charles Judge				
2600 NICHOLS AVENUE, S.E. Wash., D.C.												



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16405

1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Temple Hills</u> c. LENGTH OF STAY IN b. <u>Always - 77 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4708 Temple Hills Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Temple Hills</u> d. STREET ADDRESS <u>4708 Temple Hills Road</u>			
3. NAME OF DECEASED (Type or print) <u>Maude Elizabeth PYLES</u>		4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1968</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 23, 1891</u>	9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Prince Georges County</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S. of America</u>		13. FATHER'S NAME <u>Frank H. Small</u>		14. MOTHER'S MAIDEN NAME <u>Annie Norris</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Son - Carlton Pyles</u> Address <u>4314 Temple Hills Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Arteriosclerosis Generalized</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis - Left Hemiplegia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>20 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> <u>1961</u> , to <u>November 22, 1968</u> , that (I) (we) last saw the deceased alive on <u>November 21, 1968</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Walcutt W. Gibson</u>		22b. DATE SIGNED <u>November 22, 1968</u>		22c. PHYSICIAN'S NAME (Type) <u>Walcutt W. GIBSON</u>			
22d. ADDRESS <u>4314 Temple Hills Road</u> <u>Marlow Heights</u>		22e. REC'D BY REGISTRAR <u> </u> 22f. REGISTRAR'S SIGNATURE <u> </u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 26, 68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Barnabas Cemetery</u>			
23d. LOCATION (City, town or county) <u>Oxon Hill, Maryland</u>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>		ADDRESS <u>Wash. SE. DC.</u>		25. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u>			
25c. DATE <u>NOV 26 1968</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16406

16420

1. DECEASED-NAME (Type or print) KATHERYN		First REA		Middle REA		Last REA		2a. DATE OF DEATH Nov Month 7 Day 19 Year 68		2b. HOUR 10:45 A	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH FEB 22 1879		6. AGE (In years last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN _____	
7a. BIRTHPLACE (State or foreign country) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE'S				Md	
10. CITY OR TOWN OF DEATH HYATTSVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HYATTSVILLE Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Gov't		12b. KIND OF BUSINESS OR INDUSTRY Gov't					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE WASH. D.C.		13b. COUNTY PRINCE GEORGE'S		13c. CITY OR TOWN WASH. D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3355 16th St. N.W.			
14. FATHER'S NAME John L. Rea		First Rea		Middle Rea		Last Rea		15. MOTHER'S MAIDEN NAME Mary Donahoe		First Donahoe	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> no <input checked="" type="checkbox"/> or unknown <input type="checkbox"/>		16b. SOCIAL SECURITY NO. 111-11-1111		17. INFORMANT Mrs. Grace Thomas		Address 7101 Mount View S.E.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 470. DUE TO, OR AS A CONSEQUENCE OF Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Generalized visceral failure DUE TO, OR AS A CONSEQUENCE OF (c) Senility										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3 months 4 months 1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic lymphatic leukemia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____							
22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 45 , to Nov 7 , 19 68 , that (I) (we) last saw the deceased alive on Nov 2 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Robert E. Maher M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11-7-68					
22d. PHYSICIAN'S NAME (Type) Robert E. Maher M.D.		22e. ADDRESS 1835 Eye St. NW Wash D.C.									
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE 11/11/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) Prince Georges		(County)		(State)	
24. FUNERAL DIRECTOR Dr. J. J. J. J.		ADDRESS 1111 11th St. N.W.		25a. REC'D BY REGISTRAR NOV 12 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge					



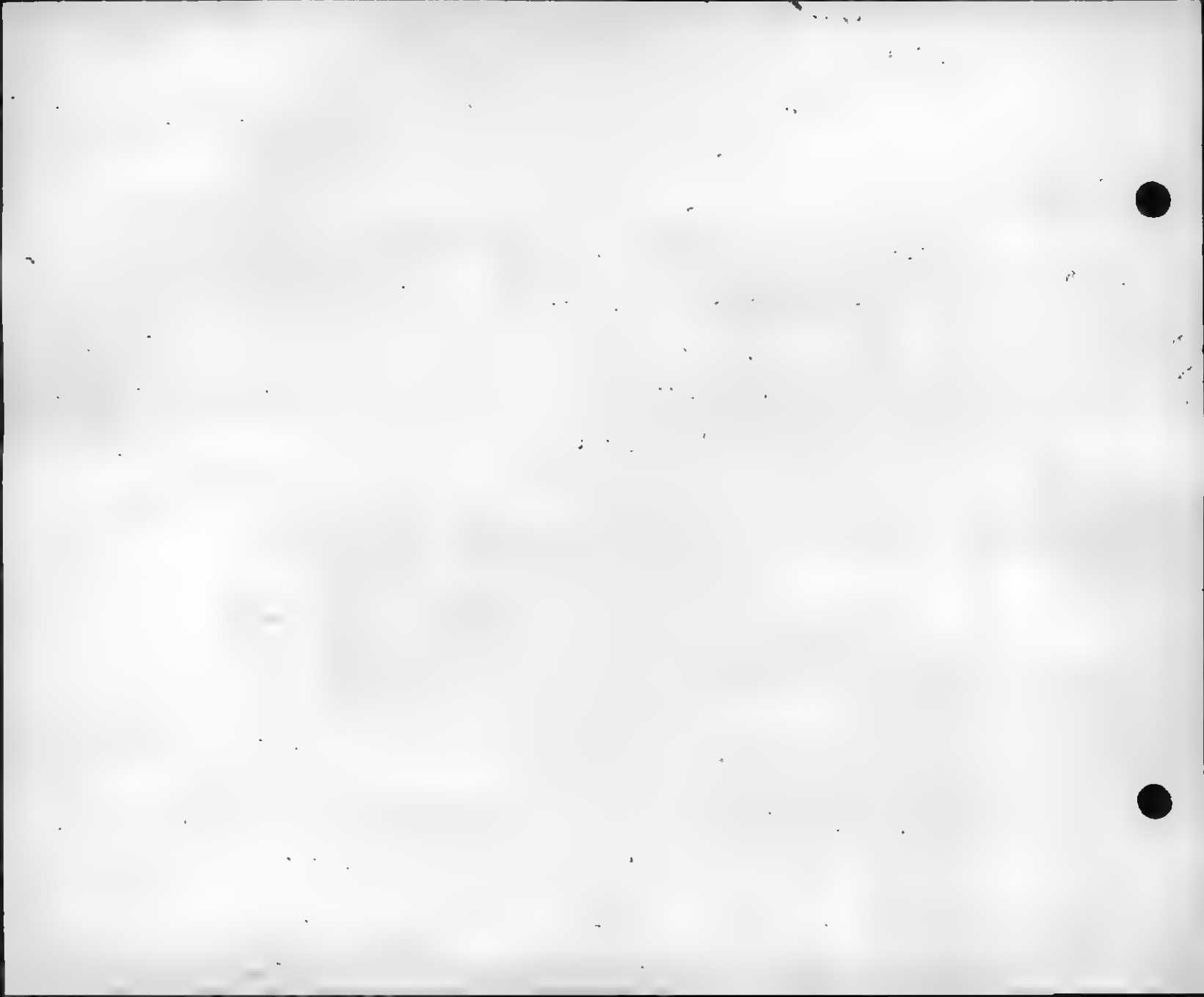
16407

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Dorothy</i>		First <i>E.</i>		Middle <i>Redmond</i>		Last <i>Redmond</i>		2a. DATE OF DEATH Month <i>Nov.</i> Day <i>3</i> Year <i>1968</i>			2b. HOUR <i>10:30</i> AM	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>DEC 10 1912</i>				6. AGE (in years lost birthday) <i>55</i> YRS.		7. IF UNDER 1 YEAR MONTHS <i>5</i> DAYS <i>10</i> HOURS <i>30</i> MINS.		
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George's</i> Md						
10. CITY OR TOWN OF DEATH <i>MT Rainier</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>3716 36th Street</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Clark</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Prince George's</i>		13c. CITY OR TOWN <i>MT Rainier</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3716 36th Street</i>				
14. FATHER'S NAME First <i>JAMES</i> Middle <i>E.</i> Last <i>Redmond</i>		15. MOTHER'S M.A.D.E.N. NAME First <i>Agnes</i> Middle <i>-</i> Last <i>McGowan</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>		(If yes give war or dates of service) <i>None</i>		16b. SOCIAL SECURITY NO. <i>579 03 8772</i>		17. INFORMANT <i>Nephew</i>		Address <i>James E. Redmond 3419 Newton St MT Rainier Md</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary emboli</i> <i>450X</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 minutes</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Yes</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. no. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>1957</i> , 19____, to <i>Nov 3, 1968</i> , that (I) (we) last saw the deceased alive on <i>Nov 2</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Leonid Levitsky</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>Nov 3, 1968</i>						
22d. PHYSICIAN'S NAME (Type) <i>Leonid Levitsky</i>		22e. ADDRESS <i>MT Rainier, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11/5/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MT Rainier Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington D.C.</i>						
24. FUNERAL DIRECTOR <i>Valley Funeral Home, MT Rainier, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>NOV 6 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

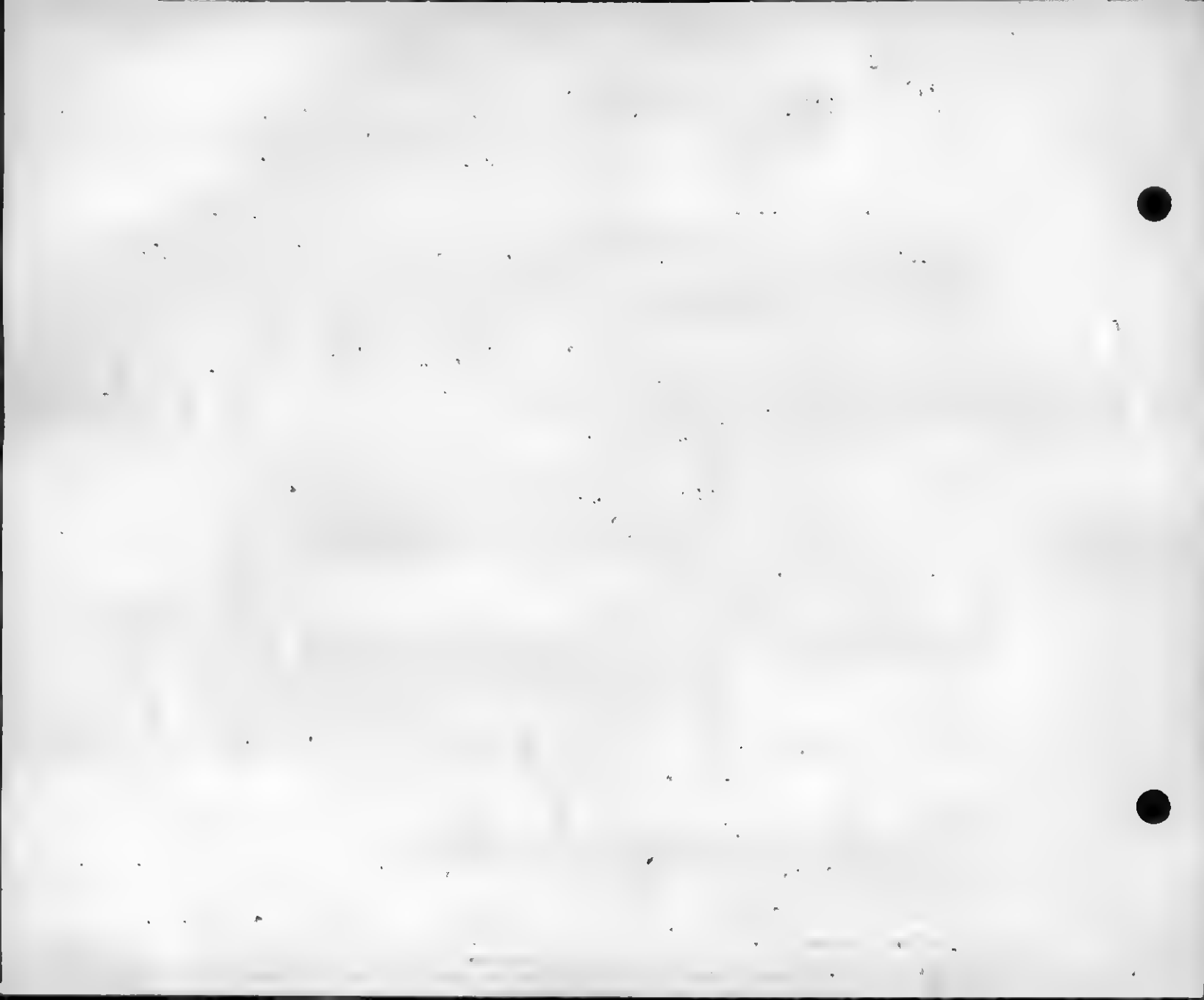


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4)
30A REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16408 CERTIFICATE OF DEATH 1642..											
1 DECEASED NAME (Type or print)			First <i>Otto</i> Middle <i>Victor</i> Last <i>Reeser</i>			2a DATE OF DEATH Month <i>Nov.</i> Day <i>25</i> Year <i>1968</i>			2b HOUR <i>3:30 PM</i>		
3. SEX <i>Male</i>			4 RACE <i>White</i>			5 DATE OF BIRTH <i>Dec. 4, 1887</i>			6 AGE (In years last birthday) <i>80</i> YRS		
7a BIRTHPLACE (State or foreign country) <i>Penna.</i>			7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Prince Georges</i> Md		
10 CITY OR TOWN OF DEATH <i>Hyattsville</i>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Hyattsville Nursing Home</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Architect</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Building</i>		
13a U.S.A. RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE <i>Md.</i>			13b COUNTY <i>Montgomery</i>			13c CITY OR TOWN <i>Rockville</i>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First <i>Otto</i> Middle <i>Reeser</i> Last <i>Kulberg</i>			15. MOTHER'S MAIDEN NAME First <i>Pauline</i> Middle <i>Xxxxxxx</i> Last <i>Kulberg</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) <i>No</i> (If yes give war or dates of service) <i>---</i>			16b SOCIAL SECURITY NO <i>578-44-9464</i>		
17 INFORMANT <i>Mrs. Samuel Smith</i>			17 ADDRESS <i>14366 Chesterfield Road, Rockville, Md.</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Vascular Accidents reported</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>months</i> <i>years</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Duchenne's myelitis</i>											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>E</i>			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (a) (the hospital) attended the deceased from <i>January</i> , 19 <i>66</i> , to <i>December 25</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/19</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b SIGNATURE <i>Harold W. Draper M.D.</i>			22c. DATE SIGNED <i>26 November 68</i>			22d. PHYSICIAN'S NAME (Type) <i>HAROLD W. DRAPER</i>			22e. ADDRESS <i>9801 GEORGIA AVE. SILVER SPRING</i>		
23a BURIAL OR CREMATION <i>CREMATION (Specify)</i>			23b DATE <i>11-29-1968</i>			23c NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>			23d LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>		
24 FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>			24 ADDRESS <i>8434 Georgia Avenue</i>			25a REC'D BY REGISTRAR DATE <i>DEC 3 1968</i>			25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16409

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1642

1. DECEASED NAME (Type or Print) First Middle Last Edward M Ries			2a. DATE KNOWN OF DEATH Month Day Year 11-2-68			2b. HOUR 10:00pm		
3 SEX Male	4 RACE White	5. DATE OF BIRTH 9-8-1892	6. AGE (in years last birthday) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 11 6 68		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Prince George Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Baker		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland			13b. COUNTY Prince George's Mt. Rainier			13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last Unknown			15. MOTHER'S MAIDEN NAME First Middle Last Unknown			13e. STREET AND NUMBER 3731 Wells Avenue		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO 578-09-6769			17. INFORMANT Edward M. Ries Jr.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(Son)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John Kehoe			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 11-7-68		
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 11/11/68			23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cem.		
23d. LOCATION (City or Town) Baltimore, Md.			23e. ADDRESS Walley's Funeral Home, Mt. Rainier, Maryland			23f. REGISTRAR'S SIGNATURE Charles Judge		
24. FUNERAL DIRECTOR Walley's Funeral Inc.			25. REC'D BY REGISTRAR NOV 14 1968			26. REGISTRAR'S SIGNATURE		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

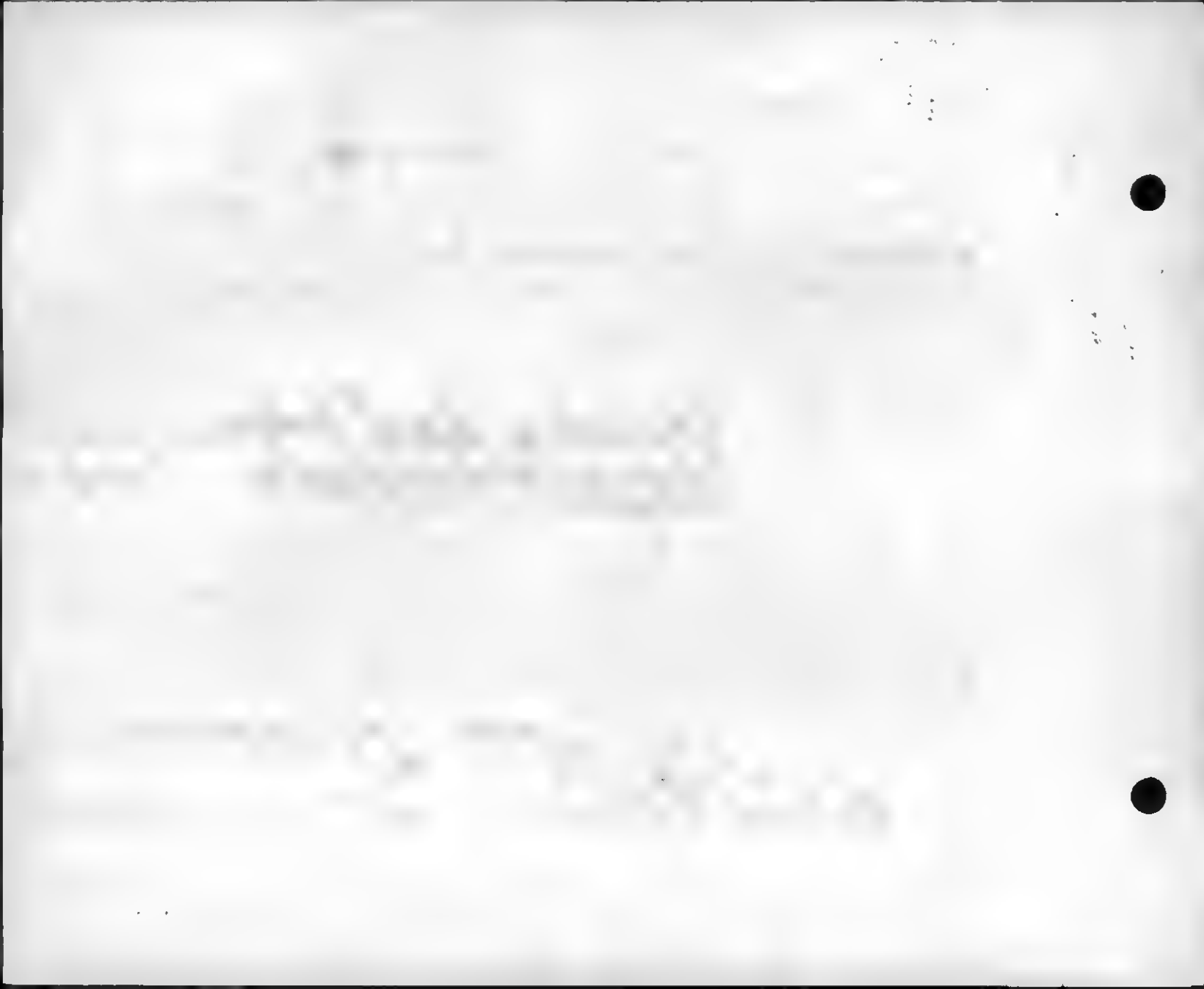
16410

16421

1 DECEASED-NAME (Type or print) <i>Charles L. Roberts</i>			2a DATE OF DEATH Month <i>Nov.</i> Day <i>25</i> Year <i>1968</i>			2b HOUR <i>9:10 A.M.</i>				
3 SEX <i>MALE</i>		4 RACE <i>WHITE</i>		5. DATE OF BIRTH <i>April 4, 1892</i>		6 AGE (in years last birthday) <i>76 YRS</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <i>Georgia</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>PRINCE GEORGE'S</i> Md.				
10 CITY OR TOWN OF DEATH <i>HYATTSVILLE</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>HYATTSVILLE Nursing Home</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>WASH. DC</i>			13b COUNTY		13c CITY OR TOWN <i>WASH. D.C.</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>1022 TAUSSIG PI N.E.</i>	
14 FATHER'S NAME First Middle Last <i>Gloster J. Roberts</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>Lula Richards</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) <i>Yes WWI</i>			16b. SOCIAL SECURITY NO			17 INFORMANT Address <i>Raymond Vernon</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF <i>Chronic Arteriovascular Hypertensive Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>15 months</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4422</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <i>11-27-68</i> to <i>11-24-68</i> , that (I) (we) last saw the deceased alive on <i>11-24-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <i>Robert C. Hance</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>11-25-68</i>		
22d. PHYSICIAN'S NAME (Type)			22e ADDRESS							
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b DATE <i>11/27/68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>		
24. FUNERAL DIRECTOR ADDRESS <i>Lee Funeral Home Washington, D.C.</i>						25a REC'D BY REGISTRAR <i>DEC 3 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



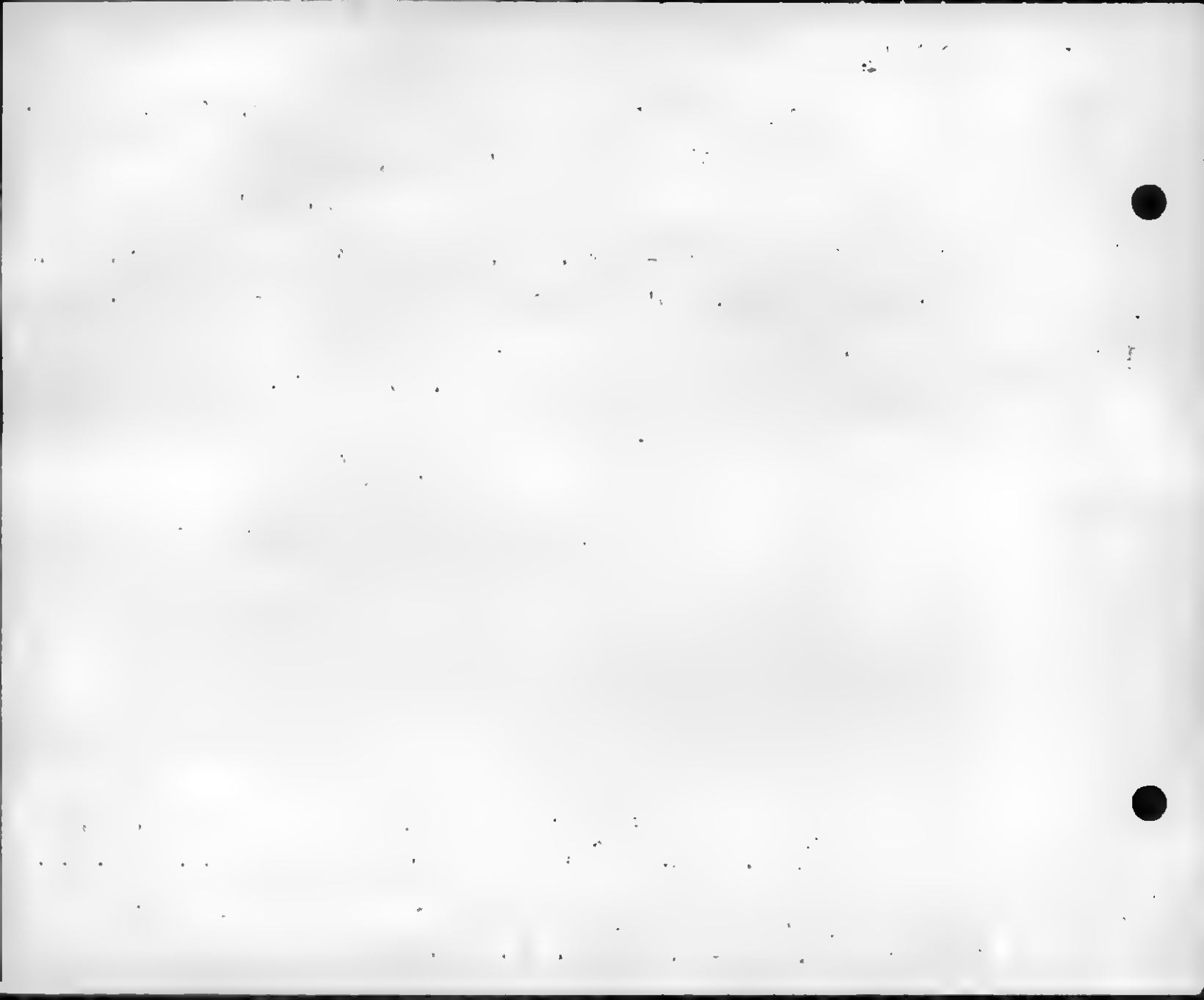
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 514
304M REV 11-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last Aubrey G. Robey			2a. DATE OF DEATH Month Day Year Nov. 28 1968			2b. HOUR 5 P.M.			
3. SEX Male		4 RACE White		5 DATE OF BIRTH June 1st, 1910		6 AGE (in years last birthday) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pr. Geo's Md.			
10 CITY OR TOWN OF DEATH Forestville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3813- 81st. Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY US. Gov.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo's		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3813- 81st Ave. SE	
14 FATHER'S NAME First Middle Last John A. Robey				15. MOTHER'S MAIDEN NAME First Middle Last Mary Garner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Edna M. Robey (Wife) Same as # 10					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive cardiac disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 6 years unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from March 5, 1962 , to Nov 28, 1968 , that (I) (we) last saw the deceased alive on Oct 14, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.									
22b. SIGNATURE Henry G. Hadley				DEGREE ATTENDING PHYS. EX MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Nov. 28, 68			
22d. PHYSICIAN'S NAME (Type) Henry G. Hadley		22e. ADDRESS 4601 Nichols Ave., S.W., Wash. D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Dec. 2-1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR Simmons Bros		ADDRESS Simmons Bros. 1661-Gd. Hope Rd. SE. Wash. DC		25a. REC'D BY REGISTRAR DEC 3 1968		25b. REGISTRAR'S SIGNATURE William J. Jones			



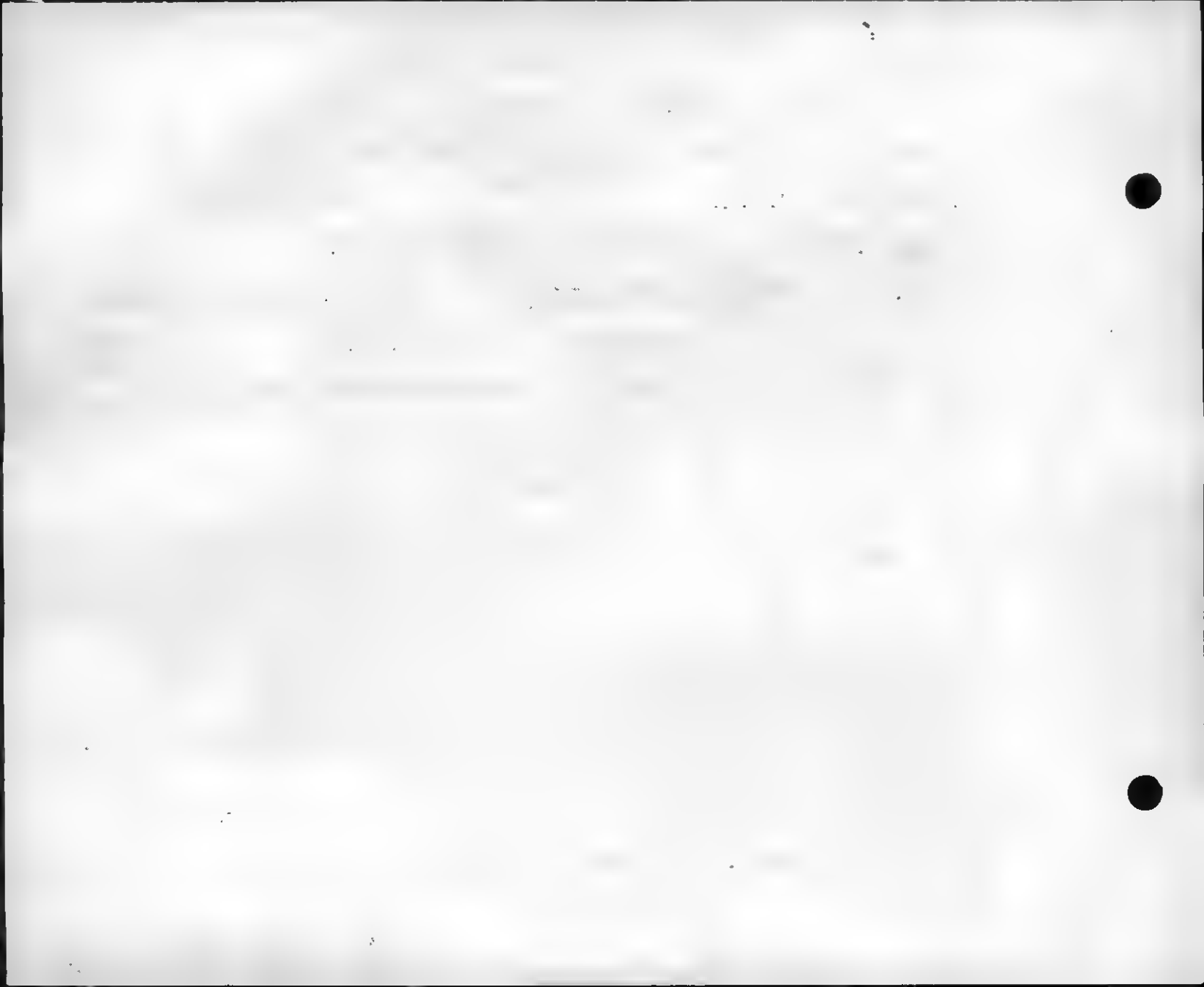
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16412

16420

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR 10 A M	
WINNIE		FAY	ROGERS	NOV 6 68				
3. SEX FEMALE		4. RACE CAUC		5. DATE OF BIRTH 6 June 1927		6. AGE (In years last birthday) 41 YRS		IF UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) N. CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH PRINCE GEORGE'S Md.		
10 CITY OR TOWN OF DEATH ANDREWS AFB		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MALCOLM GROW USAFHOSP		12a USUAL OCCUPATION (Kind of work done during last week of life, even if retired.) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) MD. STATE		13b CITY OR TOWN PRINCE GEORGE		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET AND NUMBER 5951 23RD PARKWAY		
14. FATHER'S NAME First Middle Last FINLEY MAINER		15. MOTHER'S MAIDEN NAME First Middle Last LOUISE DAVIS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. UNK		17 INFORMANT CHARLES R ROGERS SAME AS #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4212 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 MIN 1 DAY 4 YRS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 433								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that he (this hospital) attended the deceased from <u>6 Nov</u> , 19 <u>68</u> , to <u>6 Nov 68</u> , that he (we) last saw the deceased alive on <u>6 Nov 68</u> 19 <u>68</u> , and that in our (our) opinion death occurred on the date and hour and from the causes stated above. he (we) did (did not) view the body after death.								
22b. SIGNATURE <u>Leonard Farber</u>		DEGREE CAPT		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 6 Nov 68		
22d. PHYSICIAN'S NAME (Print) LEONARD FARBER, CAPT USAF MC		22e ADDRESS MALCOLM GROW USAFHOSP ANDREWS AFB						
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE Nov. 11, 1968		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCAT On (City or Town) (County) (State) Southland, Maryland		
24. FUNERAL DIRECTOR W. W. CHAMBERS CO. 511 11th St. SE. DC		ADDRESS Wash.		25a. REC'D BY REGISTRAR DATE NOV 12 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...		

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If ineligibility remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
AGNES			ROLAND			Month Day Year			4:18 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Female		white		11/22/1876			9/29 YRS		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.				PRINCE GEORGE Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
CLINTON, MD			ONE VIEW GARDENS								
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.			PRINCE GEORGE			CLINTON					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
WILLIAM SHORNE			AGNES BELL								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
NO			577-68-7769			ARTHUR TAYLOR, OXON HILL, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>removal of malignant cystic bladder</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CH of bladder</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
ALFRED R. LAPIN, MD										11-25-68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
ALFRED R. LAPIN, MD						CLINTON, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		11-27-68		PROVIDENCE CEMETERY		FRIENDLY, P.G., MD.					
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Smith Funeral Home, Waldorf, Md.								DATE NOV 29 1968		J. Charles Judge	

20601



FOR STATE HEALTH DEPT.

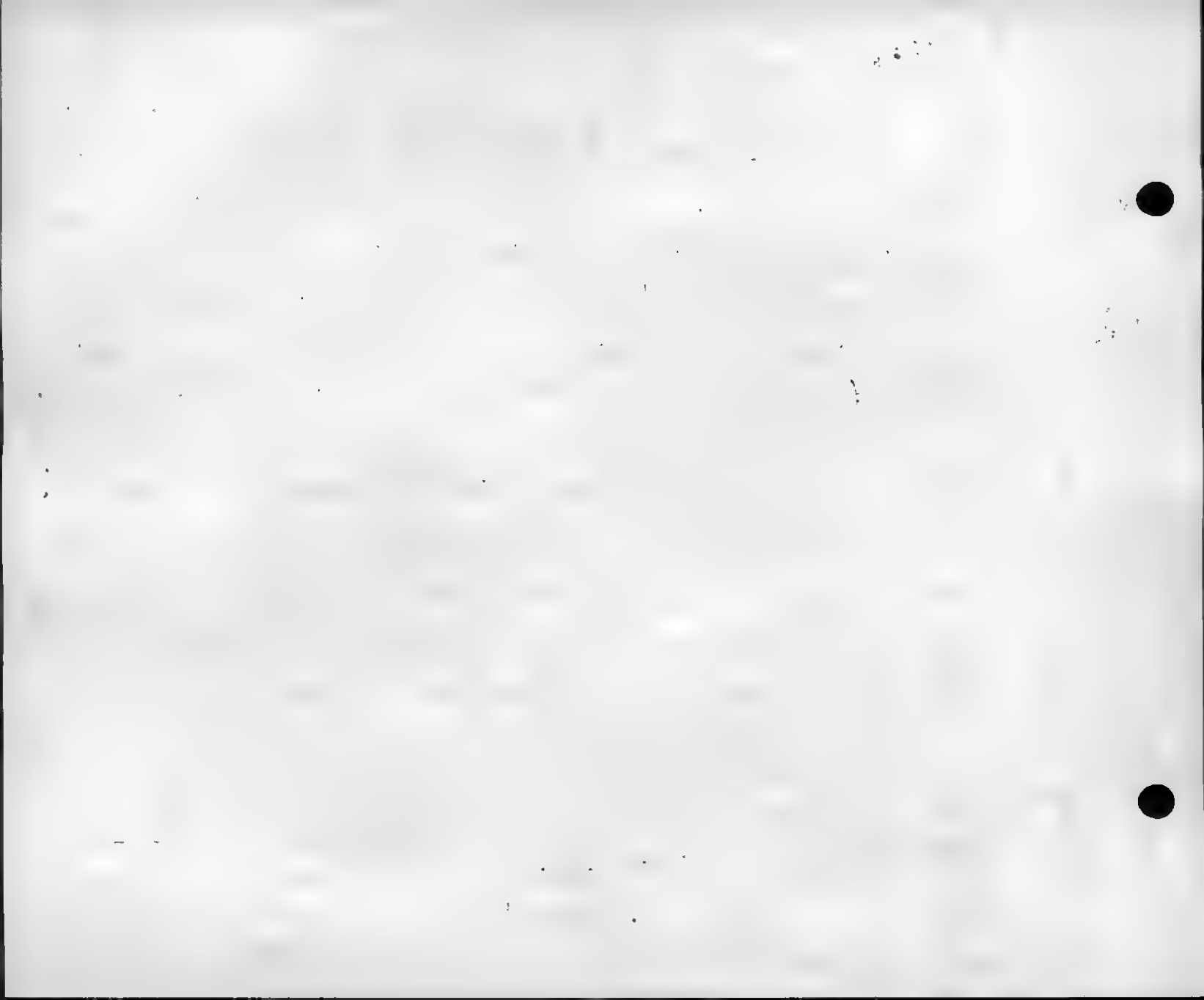
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Martin A Rooney			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 11-12-68 12:30am			2b HOUR		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 10-25-1896	6 AGE (in years last birthday) 72 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month 11 Day 12 Year 68 12:41am		
7a BIRTHPLACE (State or foreign country) Frostburg, Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md.		
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Gov't. worker		12b KIND OF BUSINESS OR INDUSTRY Air F. Base		
13a USJA. RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE Maryland		13b COUNTY Prince George's		13c CITY OR TOWN Coral Hills		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 5305 Q Street
14 FATHER'S NAME First Middle Last Michael Rooney			15 MOTHER'S MAIDEN NAME First Middle Last Ellen Barry					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO. N.A.		17 INFORMANT Frostburg, Md. Mrs. Lawrence Barry, 153 S. Water St.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Aortic stenosis (b) From Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 1 yr. over 1 yr.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Kehoe</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 11-12-68		
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE 11/15/68		23c NAME OF CEMETERY OR CREMATORY St. Michael's Cem.		23d LOCATION (City or Town) (County) (State) Frostburg, Allegany, Md.		
24 FUNERAL DIRECTOR Marilou M. Sowers, Hafer-Sowers Funeral Home, 60 W. Main, Frostburg				25a REC'D BY REGISTRAR NOV 18 1968		25b REGISTRAR'S SIGNATURE <i>Charles Yagge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
CLARENCE ARTHUR ROWE						11 Month 15 Day 68 Year			539 M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR		7. UNDER 24 MRS.	
male		white		7/11/89			79 YRS.		MONTHS DAYS		HOURS M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Canada		USA				Prince Georges Md						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Clinton			The Wood Gardens			Builder			CONSTR.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MD.			Charles		Waldorf		YES		Rt 3 Box 593-A			
14. FATHER'S NAME First Middle Last			15. MOTHER'S M.A.D.E.N. NAME First Middle Last									
CLARENCE A. ROWE												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address							
NO			21-9-22-862		HAZEL ROWE, WALDORF, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular Collapse												
185x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
(b) Ca. of Prostate												
DUE TO, OR AS A CONSEQUENCE OF												
(c) Pneumonia Hypostatic Severe												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
177x												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED White <input type="checkbox"/> Mat while at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS			22e. DATE SIGNED			
Alfred K. Lapan			ALFRED K. LAPAN			CLINTON, MD			11-15-68			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
BURIAL			Nov. 19, 1968		CEDAR HILL Cem.			SUITLAND, MD.				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Spirit Funeral Home, Waldorf, Md.			DATE 20 1968			John J. Judge						



FOR STATE HEALTH DEPT.

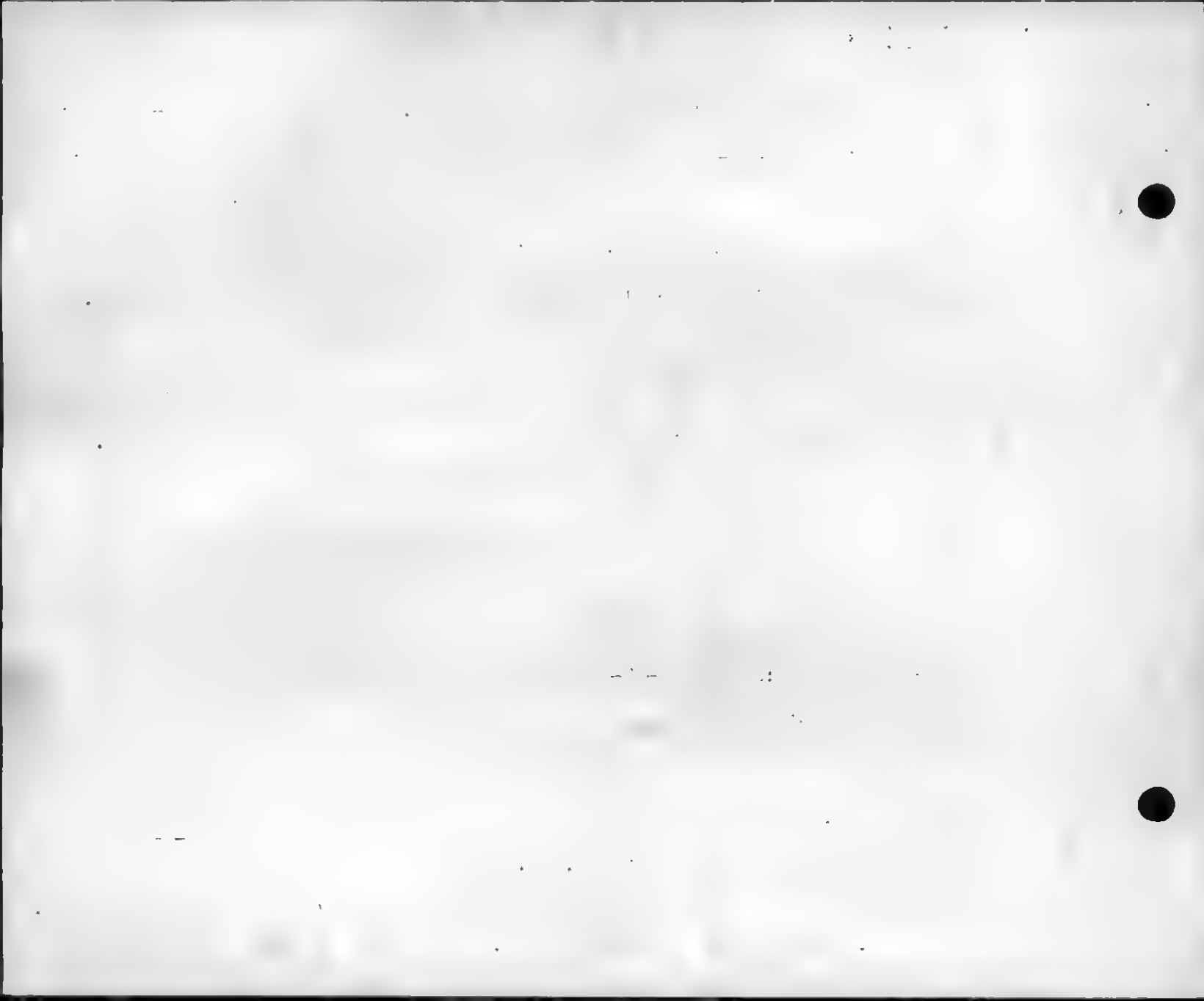
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give ages, 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16416 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #1, Film 406 11 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

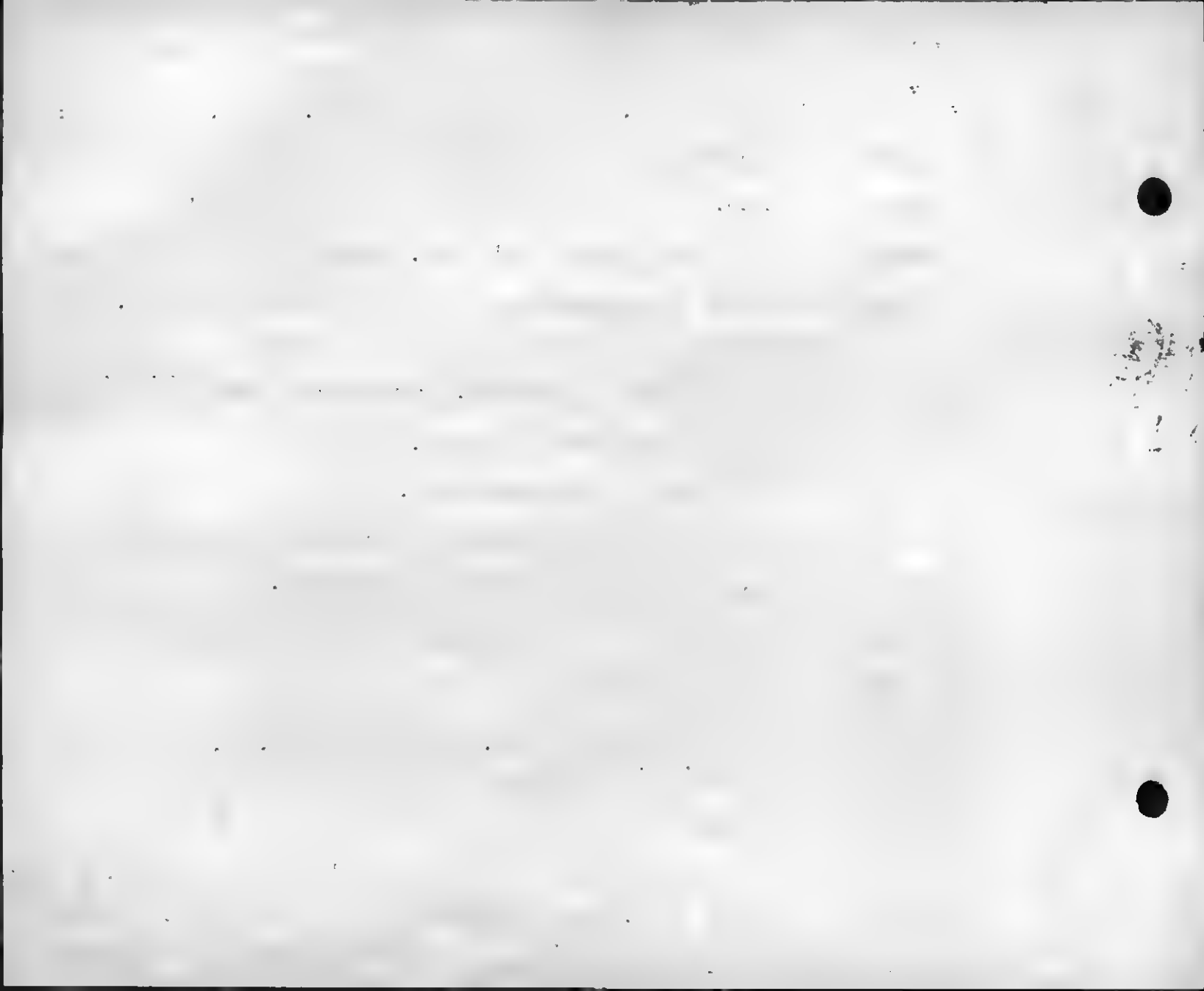
1 DECEASED-NAME (Type or Print) Richard Carver Carvie Salter Sr.			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 11 Day 4 Year 68			2b HOUR 11:30am			
3 SEX Male	4 RACE White	5 DATE OF BIRTH 3-24-1899	6 AGE (in years last birthday) 69 YRS	7 UNDER 1 YEAR MONTHS 11 DAYS 4	IF UNDER 24 HRS HOURS 11 MIN 30	2c DATE PRONOUNCED DEAD Month 11 Day 4 Year 68 19 11:30am			
7a BIRTHPLACE (State or foreign country) N C		7b CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md			
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Retired Welder		12b KIND OF BUSINESS OR INDUSTRY Railroad co		
13a USUAL RESIDENCE (Where deceased lived, if not tuition: Residence before admission) STATE Maryland		13b COUNTY Prince George's		13c CITY OR TOWN Seabrook		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 9321 Washington Blvd.	
14 FATHER'S NAME First Frank K Middle Salter Last Salter			15 MOTHER'S MAIDEN NAME First Florence Middle Taylor Last Taylor						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b SOCIAL SECURITY NO (If yes give war or dates of service) 718 14 9687		17. INFORMANT Mildred W Salter ADDRESS Seabrook, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Bilateral hemothorax (b) and multiple fractures DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min. 8 days 8 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 850X									
19a DATE OF OPERATION 850X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 8:15pm M 10-27-19 68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1B.) Run over by car					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Driveway of home		21f LOCATION Street or RFD No same as #13 City or Town Seabrook County Prince George's State Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 11-5-68	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Nov 7, 1968		23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.				25a REC'D BY REGISTRAR DATE NOV 8 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
Vita			D.		Salvia	Nov. 10, 1968		3:50PM		
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		Caucasian		11/6/92		76 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				
Italy		U.S.A.				Prince George's		Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Gen'l Hosp.			housewife		own home		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince George's		Bladensburg		YES		5800 Annapolis Rd.	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
Unknown					Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (a, or, or unknown) <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No			577-62-2317		Frank J. Cucchiara		1106 Osage Street Sil. Spr., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest (clinical).</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>579</u>										
(b) <u>Bilateral Bronchopneumonia.</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>Atelectasis of lungs due to bilateral serosanguinous</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>pleural effusions, massive - Coronary Arteriosclerosis.</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (he) (this hospital) attended the deceased from <u>Nov. 10, 1968</u> to <u>Nov. 10, 1968</u> , that (he) (we) last saw the deceased alive on <u>Nov. 10, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (he) (we) (did) (do not) view the body after death.										
22a. SIGNATURE <u>Arnold G. Brady</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <u>ARNOLD G. BRADY</u>					22e. ADDRESS <u>Prince George's General Hospital, Cheverly</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County)				
Burial		11-13-1968		St. Lincoln Cemetery		Prince Georges, Maryland				
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>					ADDRESS <u>Sil. Spr. Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 14 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

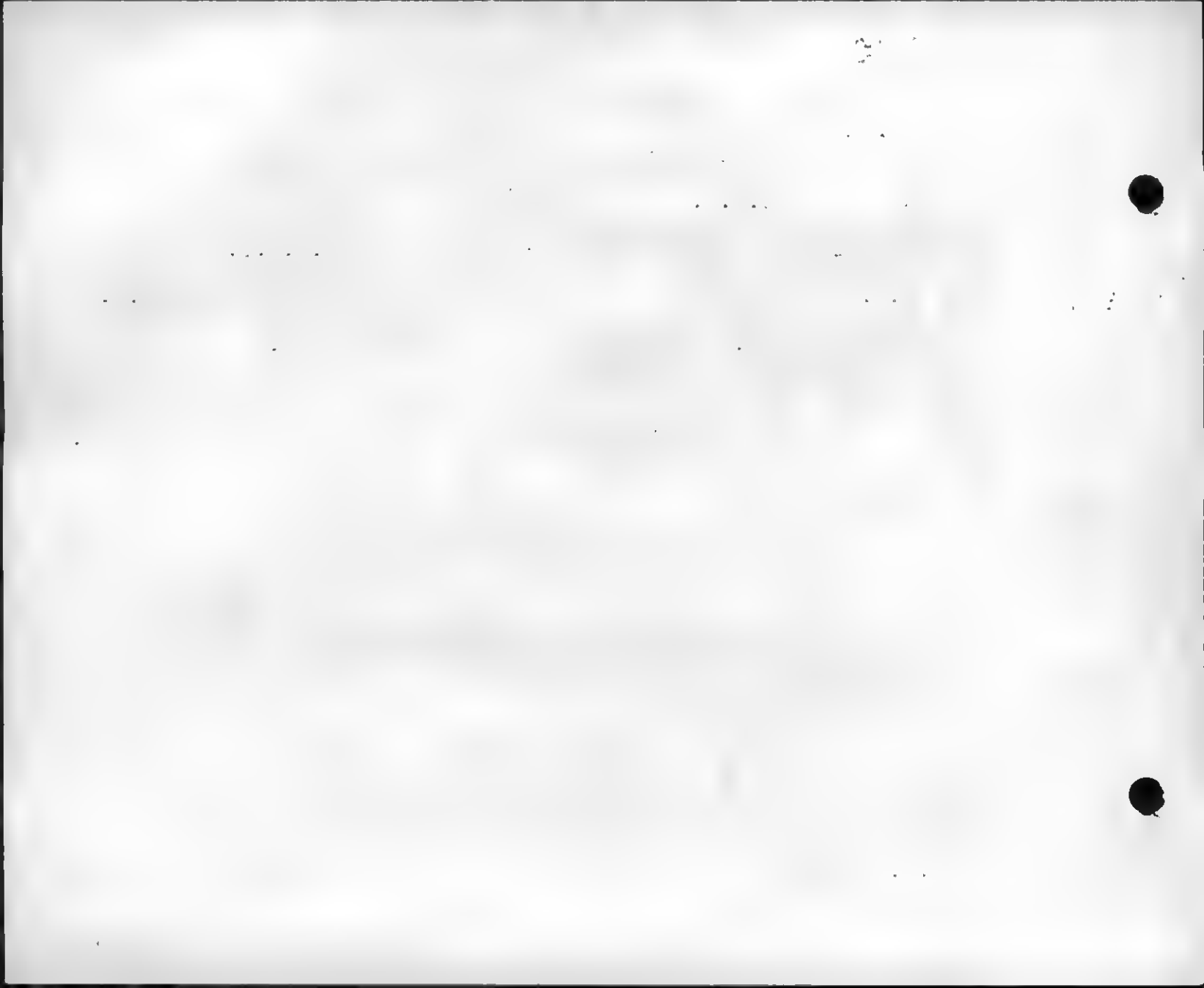


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician
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VR A15 (4)
 30M REV 1-68

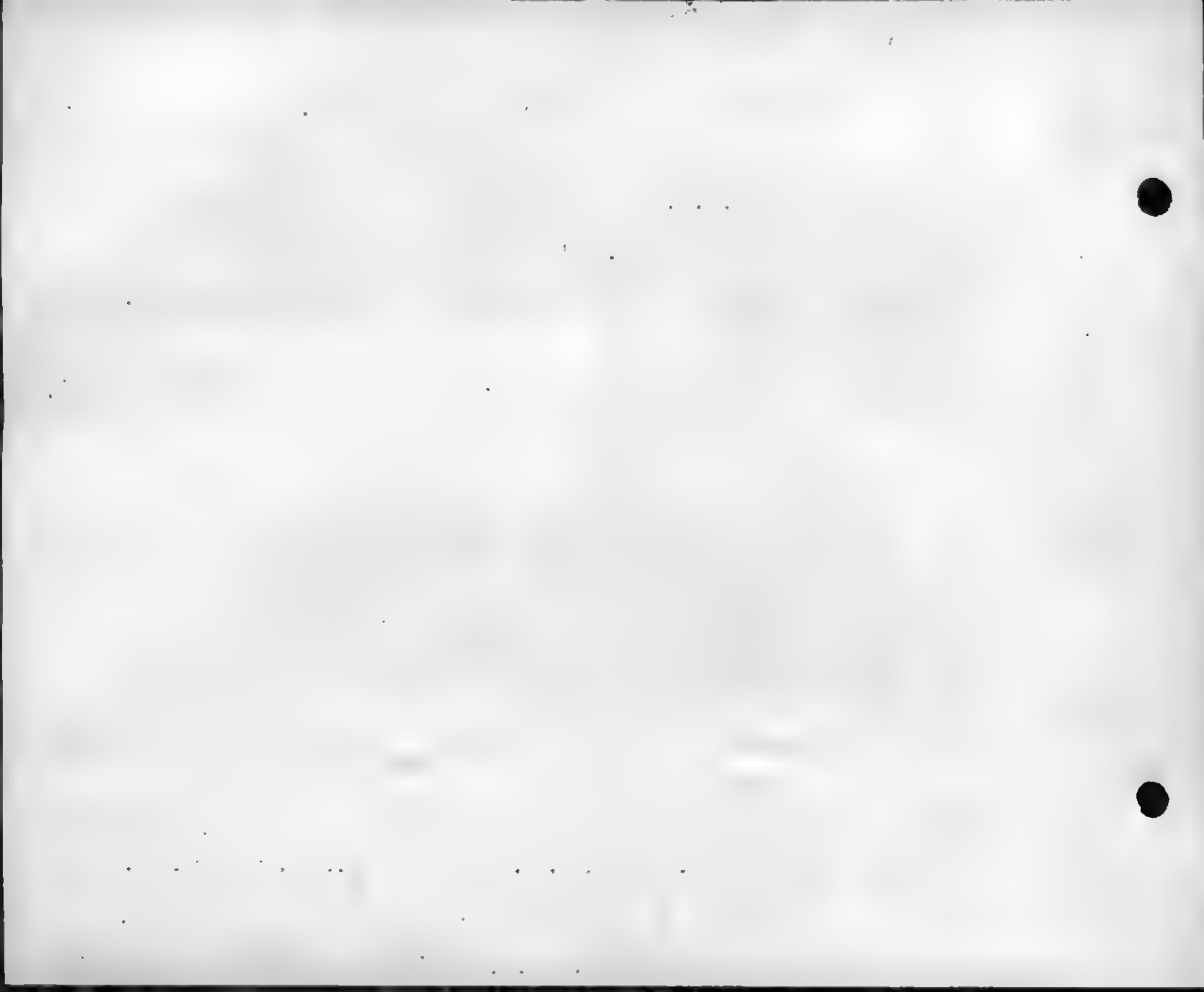
MIDDLE										LAST		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED-NAME (Type or print) JOHN ALEXANDER										SAMFORD		NOV Month 20 Day 68 Year		6:00 M	
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH 29 Aug 1905				6 AGE (In years last birthday) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) NMEX		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES Md									
10. CITY OR TOWN OF DEATH ANDREWS AFB			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAFHosp				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Gen U.S.A.F.			12b. KIND OF BUSINESS OR INDUSTRY Retired					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) Wash D.C.				13b. CITY OR TOWN Wash COUNTY D.C.		13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 5008 Fulton N.W.							
14 FATHER'S NAME First Charles Middle M. Last Samford				15 MOTHER'S MAIDEN NAME First Adeline Middle S. Last											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16b. SOCIAL SECURITY NO 1924-1960 579529222		17 INFORMANT Wife Address Same as item # 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of lung												3 mo.			
1621 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
153X															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No		City or Town		County		State					
22a. I certify that (a) (this hospital) attended the deceased from 13 Nov , 19 68 , to 20 Nov , 19 68 , that (x) (we) last saw the deceased alive on 20 Nov , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) (do) (did not) view the body after death															
22b. SIGNATURE <i>Robert H. DeVol</i>				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 20 Nov 68							
22d. PHYSICIAN'S NAME (Type) W.F. BURGER, CAPT, USAF, MC				22e. ADDRESS MALCOLM GROW USAF HOSP ANDREWS AFB											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11-25-68		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem				23d. LOCATION (City or Town) Arlington (County) Va (State)							
24. FUNERAL DIRECTOR Robert H. DeVol ADDRESS Wash. D.C.				25a. REC'D BY REGISTRAR NOV 29 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

MEDICAL CERTIFICATION



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH		
Samuel			Schonfeld				Nov.		Month 5, Day 1968 Year 9:30A M		
3 SEX		4. RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		Caucasian		11/27/83			84 YRS		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8-MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		12b KIND OF BUSINESS OR INDUSTRY		
Russia		U.S.A.					Prince George's		Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Geo. Gen'l Hospital			Jeweler					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Prince George's		Hyattsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		6700 Belcrest Rd.		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
Joseph Schonfeld			Freda --								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17 INFORMANT						
					Mrs. Dorothy Katz, 6700 Belcrest Rd. Hyattsville, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro Vascular Thrombosis										3 days	
4337 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c) Cerebro-Vascular Sclerosis											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
332X Carcinoma Colon											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING ETC		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (1) (this hospital) attended the deceased from Sept 1968, to Nov 4, 1968, that (1) (xxx) last saw the deceased alive on Nov 4, 1968, and that in my (xxx) opinion death occurred on the date and hour and from the causes stated above. (1) (xxx) (did) (did not) view the body after death.											
22b SIGNATURE Benjamin S. Miller MD DEGREE										22c DATE SIGNED 5 Nov 68	
22d. PHYSICIAN'S NAME (Type) Benjamin S. Miller, M. D.										22e. ADDRESS 3824 34th St., Mt. Rainier, Md. 20822	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 11/7/68		23c NAME OF CEMETERY OR CREMATORY King David Mem. Garden			23d LOCATION (City or Town) Falls Church, Va. (County) (State)				
Burial											
24 FUNERAL DIRECTOR Bernard Danzansky & Sons 3501 14th St. NW Wash., D.C. 20010										25a. REC'D BY REGISTRAR NOV 12 1968	
										25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Items 7 & 8 Film 006
11/12/68 kk
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
16420
CERTIFICATE OF DEATH

1643

1 DECEASED NAME (Type or print)		First Mary	Middle C.	Last Sellman	2a DATE OF DEATH Month November		Day 1	Year 1968	2b HOUR 8:45PM	
3 SEX Female		4 RACE Colored		5 DATE OF BIRTH 8/1/13		6 AGE (In years last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md				
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b COUNTY Prince Geo. Upper Marlboro			13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Box 3919		
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coma & failure</u> <u>1570</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Generalized carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of the head of the pancreas</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (X) (this hospital) attended the deceased from <u>October 26, 1968</u> , to <u>Nov. 1, 1968</u> , that (X) (we) last saw the deceased alive on <u>Nov. 1, 1968</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>E. D. Mourtzanakis</u>					DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED 11/3/68	
22d PHYSICIAN'S NAME (Type) E. D. Mourtzanakis, M. D.					22e ADDRESS Prince Georges General Hosp., Cheverly, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 11-6-68		23c NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d LOCATION (City or Town) (County) (State) Southland Maryland				
24 FUNERAL DIRECTOR <u>William L. ...</u>					ADDRESS 4539 - ...		25a REC'D BY REGISTRAR DATE NOV 6 1968		25b REGISTRAR'S SIGNATURE <u>Charles ...</u>	

VR AIS
45M



Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-3. Page 5 may be retained for your files.

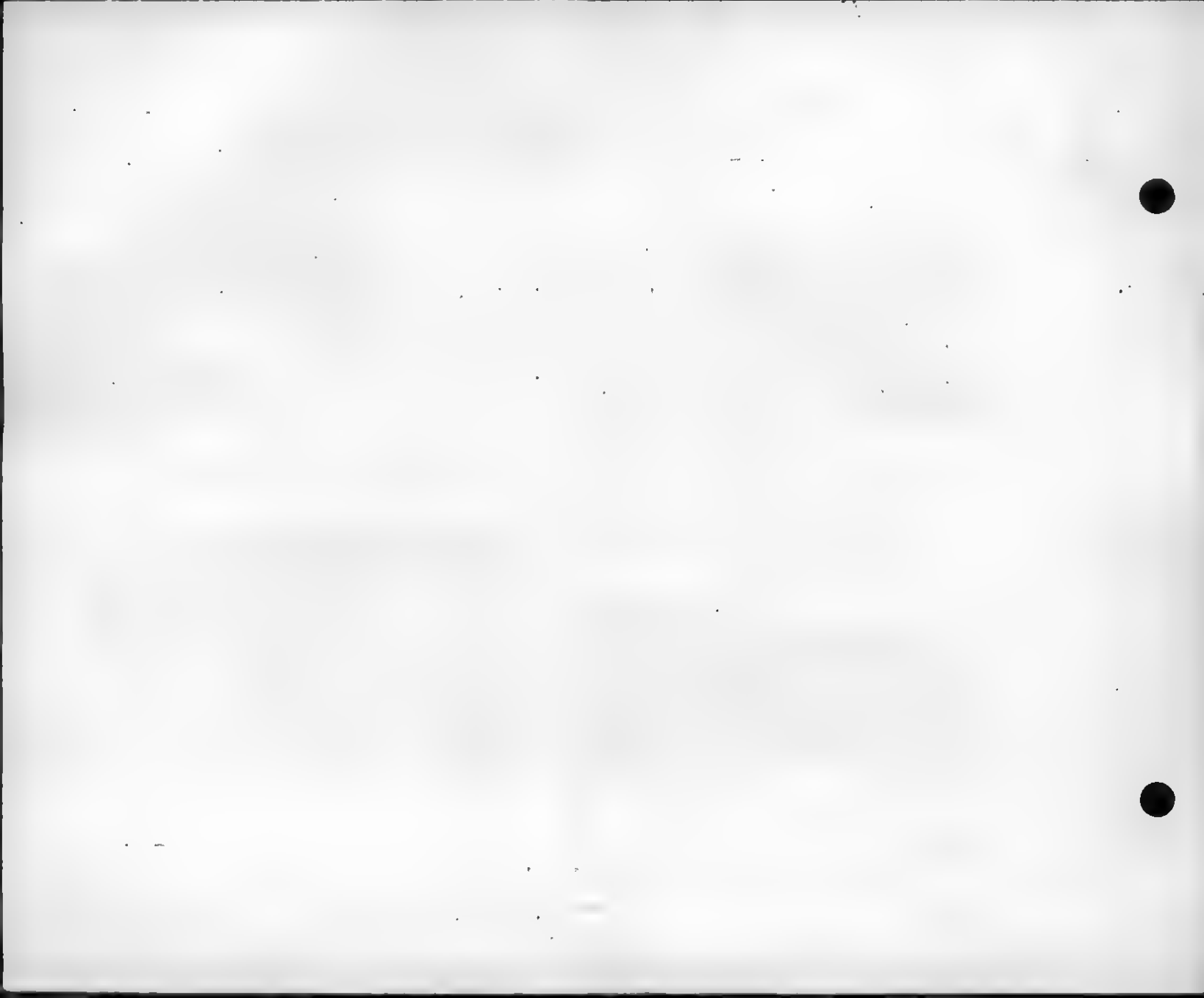
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16422

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16422

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR		
Harlen Victor Serfass						11-19-68 197:15pm					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	if UNDER 1 YEAR MONTHS DAYS		if UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	8-8-1905	63 YRS					11 19 68 197:15pm			
7a. BIRTHPLACE (State or foreign country)		7b. CT ZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
PENNA.		U.S.A.				Prince George's Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			MAINTENANCE MAN			MOTEL		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. CO. CITY		13c. CITY OR TOWN		13d. INSIDE CITY (Y/N)		13e. STREET AND NUMBER		
Maryland			Prince George's		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4705 Oglethorpe Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
UNKNOWN			UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
UNKNOWN			577-20-6701		ROBERT KIRK 8419 BALTIMORE AVE, COLLEGE PARK MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure										minutes	
DUE TO OR AS A CONSEQUENCE OF Arteriosclerotic heart disease										over 1 year	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.				City or Town		County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED			
John Kehoe		John Kehoe MD Riverdale, Md.						11-20-68			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		11/22/68		GEORGE WASHINGTON MEM. PK.		HYATTSVILLE, PR. GEO. M.D.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W.W. CHAMBERS CO.				RIVERDALE, M.D.				DATE NOV 26 1968			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
16423 EDWARD W. SHAFFER CERTIFICATE OF DEATH 16423												
1 DECEASED-NAME (Type or print) First Middle Last EDWARD W. SHAFFER						2a. DATE OF DEATH Month Day Year Nov. 8 1968			2b. HOUR 9:10 M			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH 3-26-1890			6 AGE (In years lost birthday) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) LAUREL, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE MD						
10. CITY OR TOWN OF DEATH LANHAM MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MAGNOLIA GARDENS NURS. HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BROKER			12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.				13b. COUNTY V		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2727 29TH ST. N.W.		
14. FATHER'S NAME First Middle Last CHARLES SHAFFER				15. MOTHER'S MAIDEN NAME First Middle Last -								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown? (If yes give war or dates of service) NO				16b. SOCIAL SECURITY NO. -		17 INFORMANT RT. #1, DAVIDSON WALKER, MD. MRS. ELEANORA S. CARSON, DAUGHTER						
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4124 <u>HYPOTHYROIDISM</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (1) (this hospital) attended the deceased from <u>OCT 9</u> , 19 <u>68</u> , to <u>NOV 8</u> , 19 <u>68</u> , that (1) (we) last saw the deceased alive on <u>NOV 7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Leon R. Lewitzky, M.D.</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>NOV 8 1968</u>				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-11-1968		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Laurel, Prince Georges Co. Md.					
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., N.W., Wash., D.C., 20016						ADDRESS 5130 Wisc. Ave.		25a. REC'D BY REGISTRAR DATE NOV 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form R-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 21c Film 409 2-53 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH ESTI- MATED			2b HOUR		
Charles Otis Shark						11-10-68 1954			45amM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c DATE PRONOUNCED DEAD		2d HOUR	
Male	Negro	8-25-1927	41 YRS					11 10 68		196:09am M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
S.C.		U.S.A.				Prince George's Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Cook			U.S. Govt		
13a USUAL RESIDENCE (Where deceased lived, if institution admission)			13b CITY OR TOWN			13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d STREET AND NUMBER		
District Of Columbia			Washington			YES			611 Anacostia Avenue		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
Esias Shark			Lula Gantt								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
YES			WW2			Olivia Shark			611 Anacostia Ave NE		
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain fr skull fracture											
DUE TO, OR AS A CONSEQUENCE OF (b) and Shock from hemoperitoneum from liver										Minutes	
DUE TO, OR AS A CONSEQUENCE OF (c) laceration											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
			5:40am 11-10- 19 68			Passenger of car, thrown from car and struck by two other cars.					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
			Access road from Kenilworth Ave. to Balt. Wash. Parkway, P.G. Co., Md.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b DATE SIGNED		
John Kehoe MD									11-11-68		
EXAMINER'S NAME (Type)			John Kehoe MD Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
			11-15-68		Church Cemetery Canadys S.C.						
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE			
H. S. Washington			4925 Dennc Ave NE			NOV 14 1968		Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16425

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16425

1 DECEASED NAME (Type or Print) Steven R Shipe			2a DATE KNOWN OF DEATH EST. MATED <input checked="" type="checkbox"/> 11-24-68 19 7			2b HOUR M		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 4-26-1952	6 AGE (in years last birthday) 16 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year 11 25 68 19 8:21am M		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md		
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) student		12b KIND OF BUSINESS OR INDUSTRY school		
13a USUAL RESIDENCE (Where deceased lived, if not in hospital give street address) STATE Maryland		13b COUNTY Prince George's		13c CITY OR TOWN Laurel		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 14 E Contee Road
14 FATHER'S NAME First Middle Last Charles W. Shipe			15 MOTHER'S MAIDEN NAME First Middle Last Beverly Anne Rhys					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) no		16b SOCIAL SECURITY NO		17 INFORMANT Beverly Shipe		ADDRESS 14 E. Contee Rd. Laurel Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gun shot wound of head</u> 155 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1700								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 11-24 1968 PM P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Shot self with .22 cal rifle.				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) Wooded area 20 yards in rear of home		21f LOCATION Street or R.F.D. No same as #13		City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD			MD John Kehoe MD Riverdale, Md.			22b DATE SIGNED 11-25-68		
23a BURIAL CREMATION Burial			23b DATE 11-27-68		23c NAME OF CEMETERY OR CREMATORY St. Cecilia		23d LOCATION (City or Town) (County) (State) Colman Manor Md.	
24 FUNERAL DIRECTOR Charles Lee Funeral Home Laurel Md.				ADDRESS		25a REC'D BY REGISTRAR DATE NOV 29 1968		25b REGISTRAR'S SIGNATURE Charles Judge



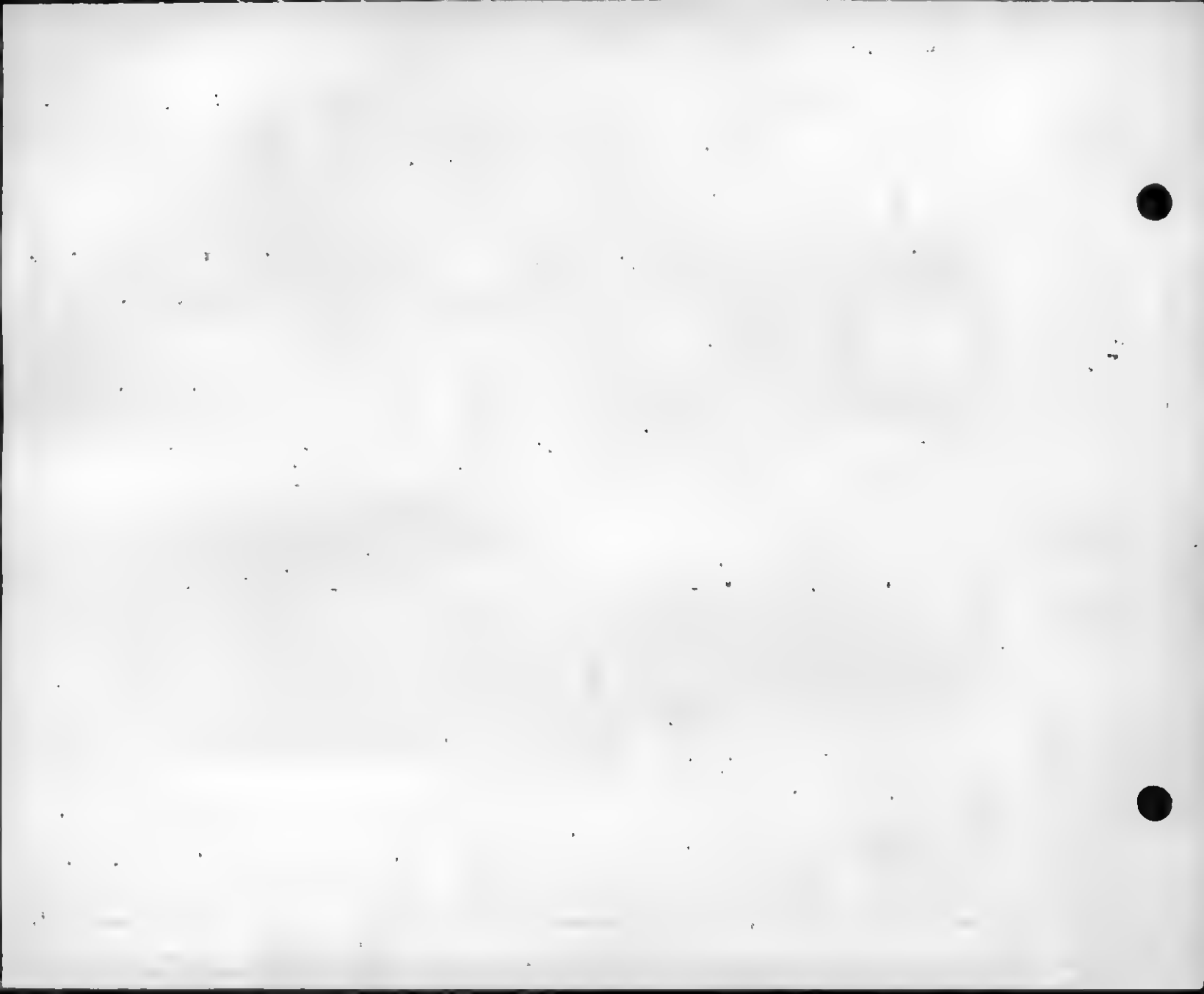
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-15-64
30M REV. 11/68

<div style="text-align: center;"> <p>16426</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>CERTIFICATE OF DEATH</p> </div>											
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR		
Paul R Shipley						Nov. Month 14 Day 1968			9:05 PM		
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
male		white		Dec 6, 1895			72 YRS				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH				
Md		U S A					Prince George's			Md	
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Beltsville			4909 Olympia ave			Retired Defence Dept			U S Government		
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Md			Pro Geo		Beltsville				4909 Olympia ave.,		
14 FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Ruben Shipley				Margaret Corbey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b SOCIAL SECURITY NO		17. INFORMANT			Address		
yes				213 24 3633		Kathryn E Shipley			Beltsville, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of the Lung</u>										6 wks	
1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
1 Arteriosclerotic Cardiovascular Disease											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April, 1967, to 14 Nov., 1968, that (I) (we) last saw the deceased alive on 14 Nov., 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Wm A Winsatt M.D.</u> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c DATE SIGNED 14 Nov. 68		
22d. PHYSICIAN'S NAME (Type) Wm A Winsatt						22e ADDRESS 3415 Hamilton st Hyattsville, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Nov 18, 1968		Christians Brothers cemetery Ammendale Pro Geo Md.						
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.						25a REC'D BY REGISTRAR DATE NOV 18 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

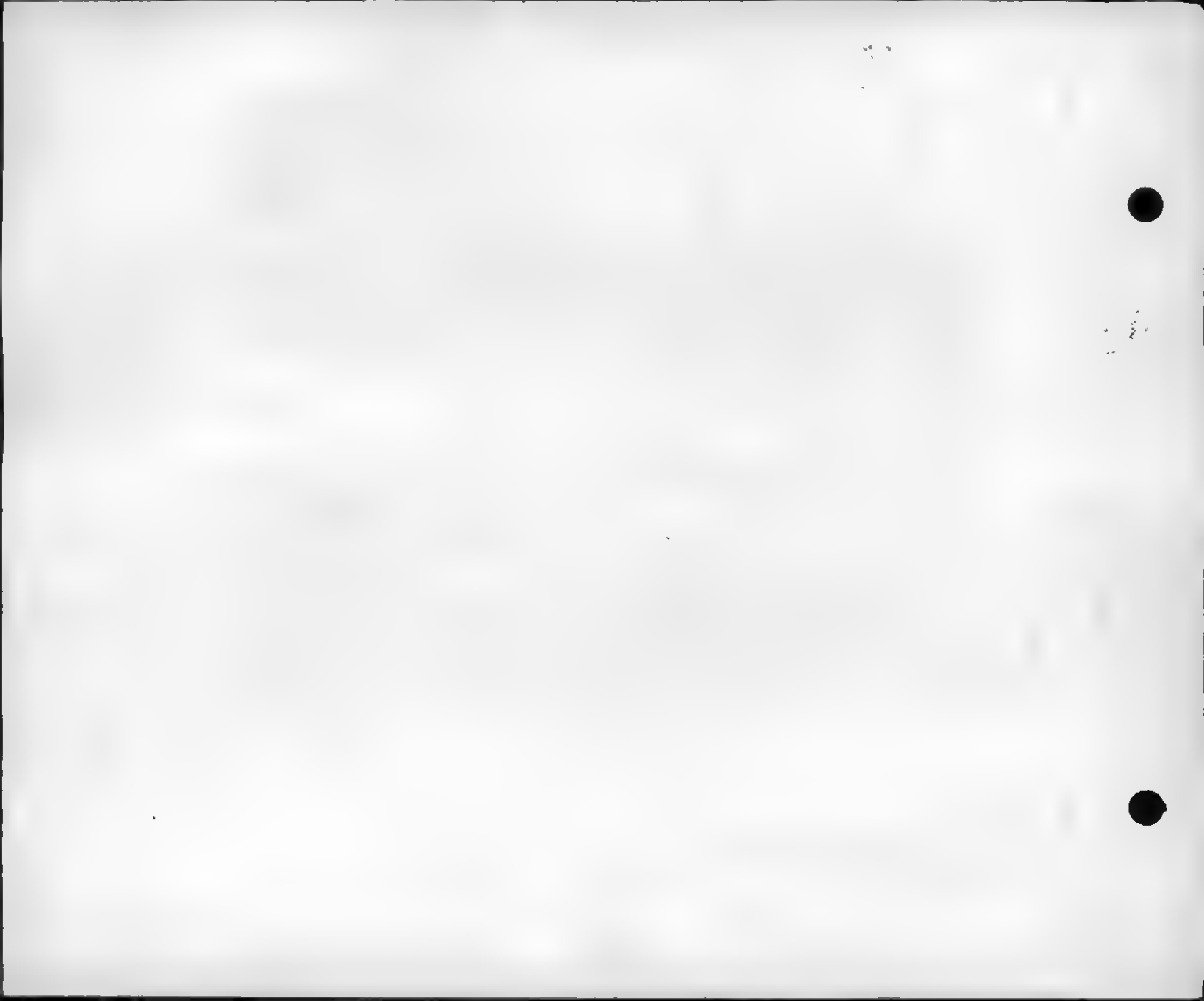
16427

10441

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>			c. LENGTH OF STAY IN TB <u>9 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1101 BURKETON STREET</u>				d. STREET ADDRESS <u>1101 BURKETON STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>EDWARD</u> Middle <u>SIMONS</u> Last				4. DATE OF DEATH Month <u>NOV.</u> Day <u>24</u> Year <u>1968</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 25, 1906</u>		9. AGE (In years last birthday) <u>62</u> yrs	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CATERING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>PETER SIMONS</u>				14. MOTHER'S MAIDEN NAME <u>AMELIA SAROFIN</u>			
15. WAS DECEASED EVER IN U.S. ARMYED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO <u>579 12 5119</u>		17. INFORMANT <u>MRS CATHERINE SIMONS</u>		Address <u>1101 BURKETON ST. HYATTSVILLE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>RHEUMATIC HEART DISEASE</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>4/1/68</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 YEARS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL VASCULAR THROMBOSIS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>AUGUST</u> , 19 <u>68</u> to <u>NOV. 24</u> , 19 <u>68</u> , that (I) lost lost the deceased alive on <u>NOV 23</u> , 19 <u>68</u> , and that death occurred at <u>7:35 A.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Dennis J. Hand</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/24/68</u>			
22c. PHYSICIAN'S NAME (Type) <u>DENNIS J. HAND MD</u>		22d. ADDRESS <u>4600 CONNECTICUT AVE. N.W. WASH. DC</u>					
23a. BURIAL-CREATION, REMOVAL (Specify) <u> </u>		23b. DATE THEREOF <u>11/27/1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		23d. LOCATION (City or town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Mattingly</u>		ADDRESS <u>181-11th St. S.E. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>NOV 27 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

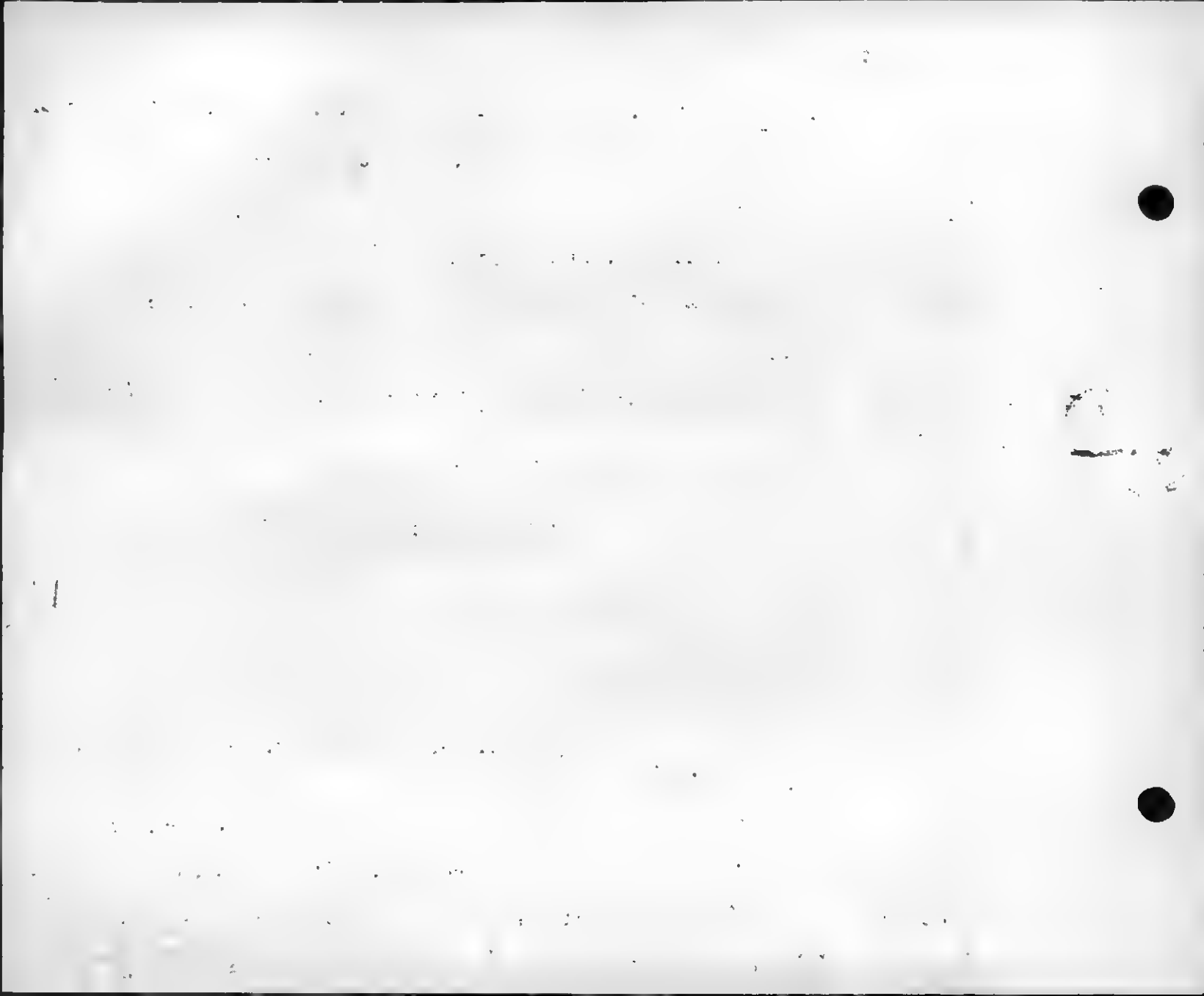
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16428

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1644

1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH				2b. HOUR			
William		H.		Skinner		Nov.		Month 18, Day 1968				5:15 PM			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		Negro		Feb. 16, 1909				59 YRS.		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH									
Chas. Co. Md.		U.S.A.				Prince George's Md									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly		Prince Geo. Gen'l Hospital				Laborer									
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER							
Maryland		Prince George's		Brandywine		YES <input type="checkbox"/> NO <input type="checkbox"/>		Route #1, Box 55							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
James		H.		Skinner				Ida		West					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address									
No		212-14-3202		Mrs. Catherine Greene		Above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)															
DUE TO, OR AS A CONSEQUENCE OF Dehydration. Hepatic coma															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
DUE TO, OR AS A CONSEQUENCE OF Diabetes. Chronic alcoholism															
(c) Hemorrhage of brain															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
		HOUR A.M. Month Day Year P.M. 19													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (he/she) attended the deceased from Oct. 18, 1968, to Nov. 18, 1968, that (he/she) last saw the deceased alive on Nov. 18, 1968, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE												22c. DATE SIGNED			
S. V. Nair, M. D.												Nov. 19, 1968			
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS			
S. V. Nair, M. D.												Prince Geo. Gen'l Hospital, Cheverly, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)					
Burial		11-22-68		St. Mary's Ch. Cem.		Bryantown, Chas. Co. Md.									
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Montel Adams, M.D.												DATE NOV 27 1968		Charles Judge	

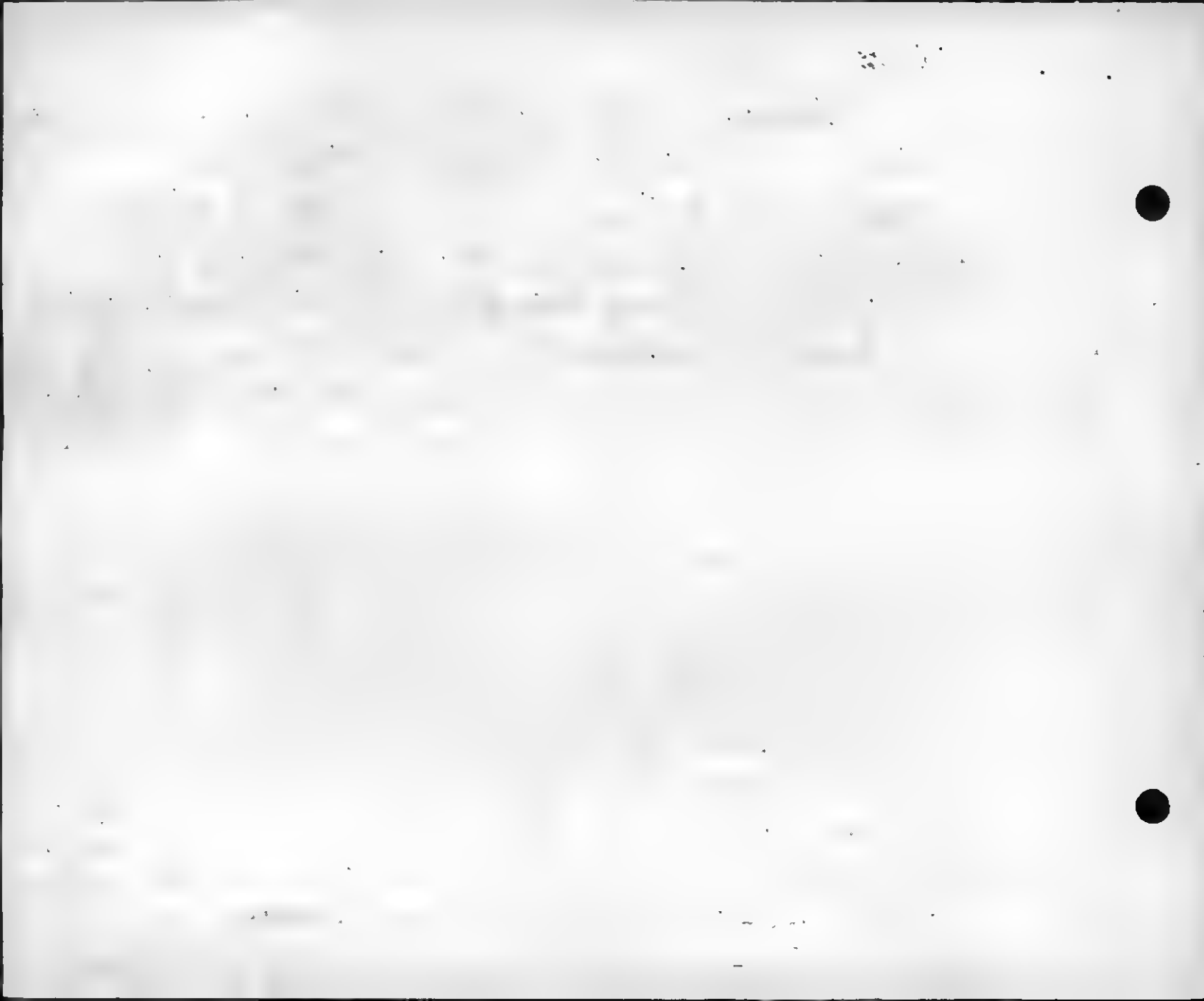


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VR A15(4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print) First Middle Last Richard K. Small					2a. DATE OF DEATH Month Day Year Nov. 13-1968			2b. HOUR 10:30 P.M.		
3. SEX Male		4 RACE White		5. DATE OF BIRTH Nov. 30-1903		6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.				
10. CITY OR TOWN OF DEATH Camp Springs		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Andrew Air Base Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Real-Estate Broker			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Pr Geo		13c. CITY OR TOWN Clinton Acres		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11800-Crestwood Ave		
14 FATHER'S NAME First Middle Last Francis H. Small			15 MOTHER'S M.A.DEN NAME First Middle Last Annie Norris							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT Dorothy Y. Small			Address Clinton Acres Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 71.9 Curbside, Liver DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 3 mos.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from Feb 10, 1950 , to Nov. 13, 1968 , that (I) (we) last saw the deceased alive on 11-12-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Frank S. Pellegrini MD					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11-13-68			
22d. PHYSICIAN'S NAME (Type) FRANK S. PELLEGRINI					22e. ADDRESS 3611 Branch Ave NE Hillcrest Hght Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-18-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland, Md			
24. FUNERAL DIRECTOR Simmons Bros.					ADDRESS Wash DC		25a. REC'D BY REGISTRAR NOV 15 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge	
25c. ADDRESS Simmons Bros 1661-Good Hope Rd SE										



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VR A15 M
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

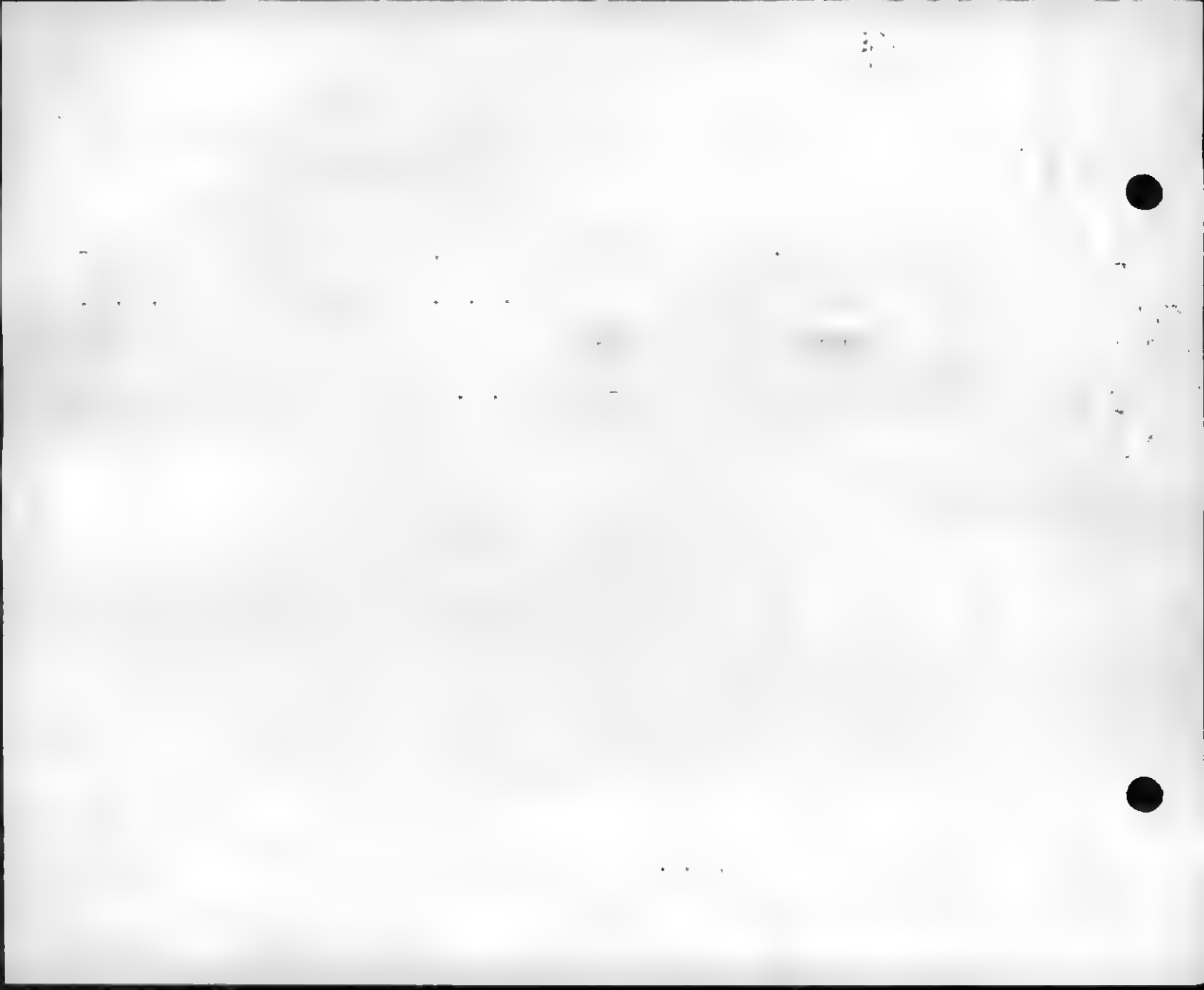
CERTIFICATE OF DEATH

16430

1644

1. DECEASED-NAME (Type or print) Elsie		First Smith	Middle Smith	Last Smith	2a. DATE OF DEATH Month 11 Day 13 Year 68			2b. HOUR 8:45	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 2/28/1897		6. AGE (In years last birthday) 71 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Glenn Dale, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Unknown		12b. KIND OF BUSINESS OR INDUSTRY --			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Prince George's		13c. CITY OR TOWN Wash. D. C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1325 Bryant St. N. E.	
14. FATHER'S NAME David		First Gorman		Last Gorman		15. MOTHER'S MAIDEN NAME Sarah		First Freeland	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 217-34-5275		17. INFORMANT D. C. General Hospital Records		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4129 Recurrent cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Multiple old cerebrovascular accidents, bilateral DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Chronic brain syndrome PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/23 , 19 66 , to 11/13/ , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/13/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE Moe Weiss		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/13/68			
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11-17-68		23c. NAME OF CEMETERY OR CREMATORY St. Edmund Ch. Cem. Sunderland		23d. LOCATION (City or Town) (County) (State) MD.			
24. FUNERAL DIRECTOR William E. Sewell		ADDRESS Prince Frederick		25a. REC'D BY REGISTRAR DATE NOV 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

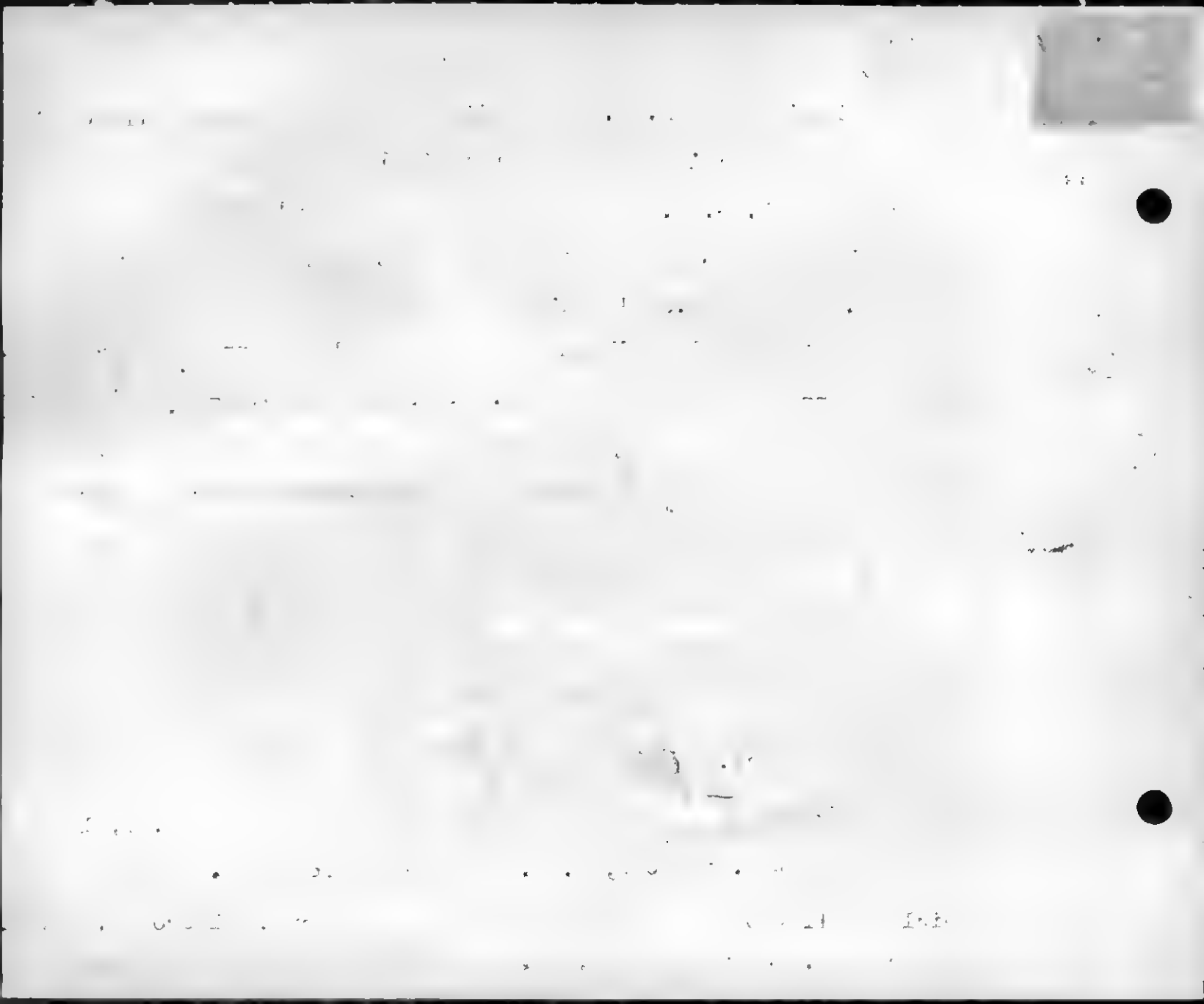


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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
Lavinia M. B. Smith						Month Day Year November 1, 1968			11:00 M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		July 23, 1876			92 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Maryland		U. S. A.					Prince Georges Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Forestville			Regent Nursing Home			Housewife			Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Pr. Geo's			Upper Marlboro			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Box #8	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME								
First Middle Last James Naylor Walls Wilson				First Middle Last Sarah -- Gibbons								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO				17. INFORMANT				
No				--				Mrs. Elizabeth Pumphrey-Ma. Upper Marlboro				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ 4409 DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos 18 yrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4500												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 15 Jan 1968 to 1 Nov 68, 1968, that (I) (we) last saw the deceased alive on Oct 31 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE								DEGREE		22c. DATE SIGNED		
Robert B. Masscer, M. D.								ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		Nov. 1, 1968		
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS				
Robert B. Masscer, M. D.								Upper Marlboro, Md. 20870				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			11/4/68		Trinity Cemetery			Upper Marlboro Pr. Geo. Md.				
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REG. STRAR		25b. REGISTRAR'S SIGNATURE		
Ritchie Bros. Upper Marlboro, Md.								NOV 12 1968		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

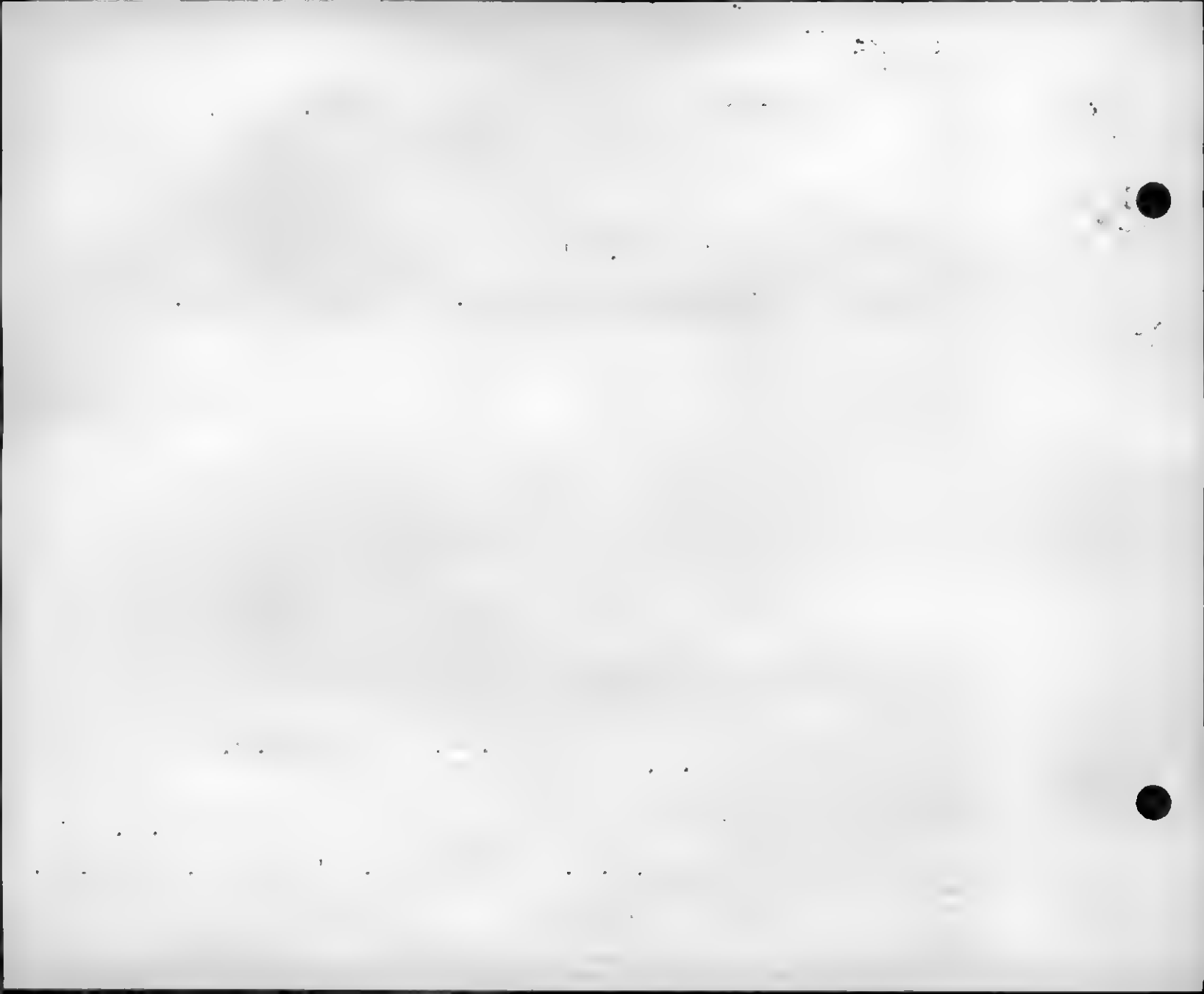
16432

Item 6 Film 450

CERTIFICATE OF DEATH

10440

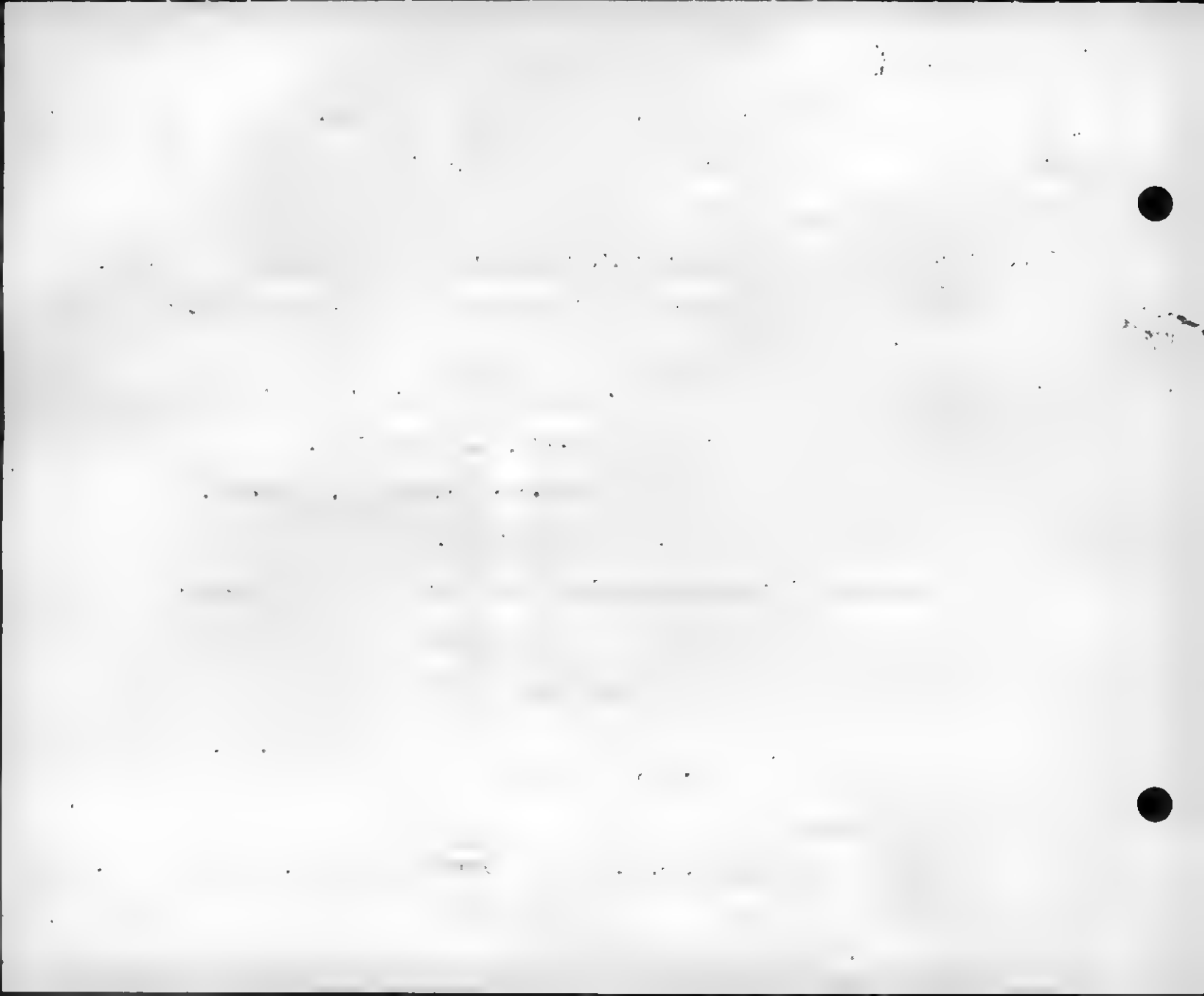
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month 1, Day 1968 Year		2b. HOUR 7:05 A.M.
Lawrence		Smith					
3 SEX Male	4 RACE Negro	5. DATE OF BIRTH Jan 13 - 1913			6 AGE (In years last birthday) 55 YRS	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) VA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED WIDOWED	NEVER MARRIED DIVORCED	9 COUNTY OF DEATH Prince George's		12b. KIND OF BUSINESS OR INDUSTRY Construction	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Cement Finisher			
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Maryland		13b. COUNTY Prince George's	13c. CITY OR TOWN Cedar Hgts.	13d. INSIDE CITY LIMITS? YES NO	13e. STREET AND NUMBER 1116 64th Ave.		
14. FATHER'S NAME First Middle Last Joseph Smith			15. MOTHER'S MAIDEN NAME First Middle Last Sally -				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Lawrence Smith Jr 1226 West St. N.E.			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC AND RESPIRATORY ARREST</u> <u>1574</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Endocardial Extension - Brain Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of the pancreas.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>151X</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES NO <u>XX</u>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that <u>xx</u> (this hospital) attended the deceased from <u>Oct. 18, 1968</u> , to <u>Nov. 1, 1968</u> , that <u>xx</u> (we) last saw the deceased alive on <u>Nov. 1, 1968</u> , and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>xx</u> (we) (did) <u>not</u> view the body after death							
22b. SIGNATURE <u>Luis F. Bentolila</u>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED Nov. 1, 1968	
22d. PHYSICIAN'S NAME (Type) Luis Bentolila, M. D.				22e. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11-5-68		23c. NAME OF CEMETERY OR CREMATORY CARVER		23d. LOCATION (City or Town) (County) (State) Muirfield Md	
24. FUNERAL DIRECTOR H.S. Washington & Sons 4925 Vance Ave NE				25a. REC'D BY REGISTRAR DATE NOV 6 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

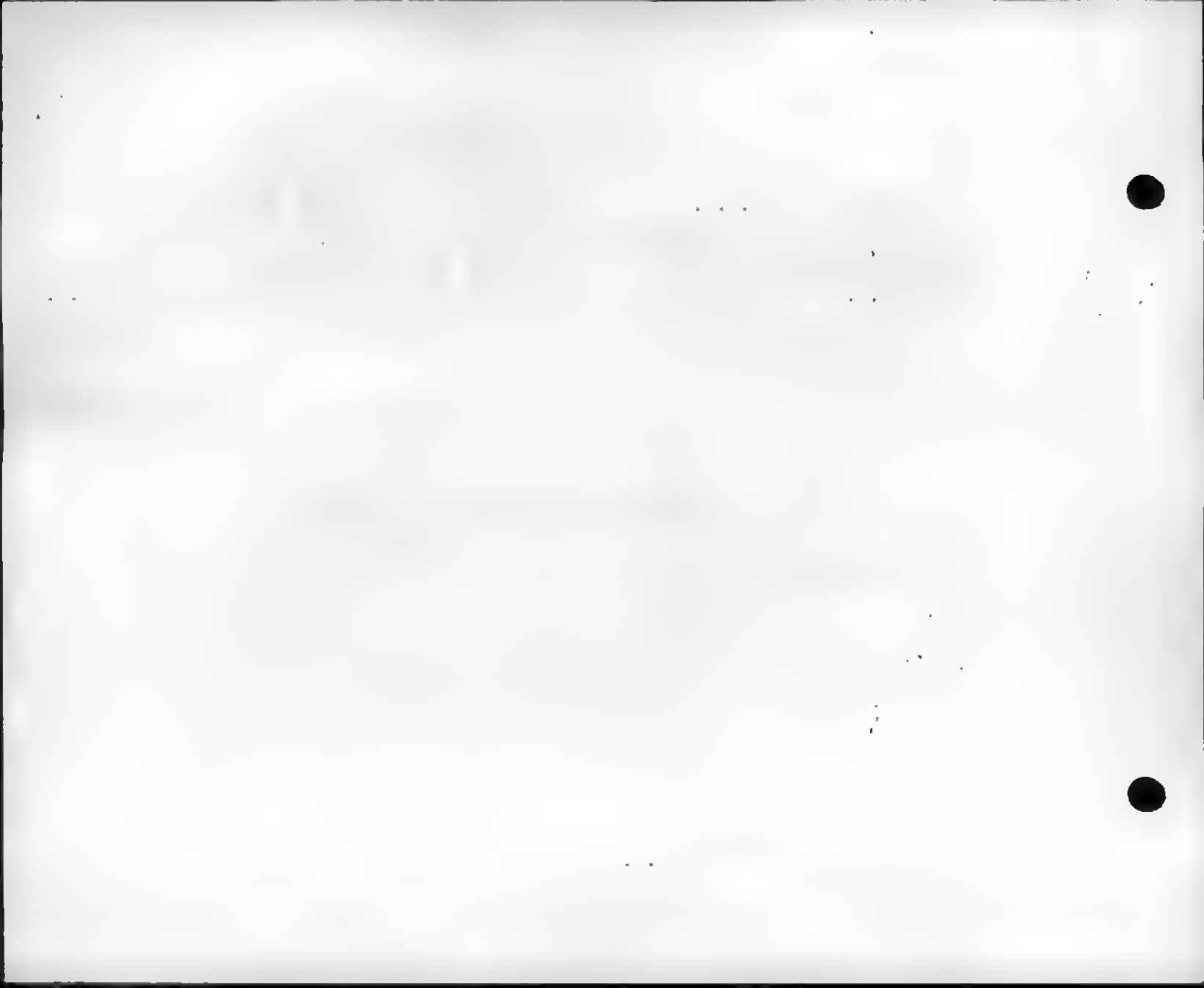
Item 8 Film 6409 2/26/69 kk										MARYLAND STATE DEPARTMENT OF HEALTH														
16433										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
16433										CERTIFICATE OF DEATH														
1. DECEASED NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR									
Clarence					O. Stephens					Nov. 11, 1968					11:15									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.									
Male			Caucasian			12/29/91			76			MONTHS DAYS HOURS MIN			HOURS MIN									
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH									
Indiana					U S A										Prince George's Md									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUA. OCCUPATION (Kind of work done during most of work ng life even if retired)					12b. KIND OF BUSINESS OR INDUSTRY									
Cheverly					Prince Geo. Gen'l Hospital					Diamond					cutter									
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE					13b. CITY OR TOWN					13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
Maryland					Prince George's College Park					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					4607 Beech Wood Road									
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																			
Wm S Stephens					Effie																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)					16b. SOCIAL SECURITY NO					17. INFORMANT					Address									
no					479 03 2564A					Kennard Stephens					College Park, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho-pneumonia, left lower lobe.																								
DUE TO, OR AS A CONSEQUENCE OF																								
Cand trans, if any, which gave rise to immediate cause (a), stating the underlying cause last. 605X																								
(b) Acute suppurative pyelonephritis, bilateral.																								
DUE TO, OR AS A CONSEQUENCE OF																								
(c) Acute purulent cystitis.																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																								
Periureteral fibrosis, bilateral with hydroureter & hydronephrosis.																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 1/10/68, 19, to Nov. 11, 1968, that (I) (xxx) last saw the deceased alive on Nov. 11, 1968, and that in (my) (xxx) opinion death occurred on the date and hour and from the causes stated above, (I) (xxx) (did not) view the body after death.																								
22b. SIGNATURE Albert Roth, M. D.															22c. DATE SIGNED 11-12-68									
22d. PHYSICIAN'S NAME (Type) Albert Roth, M. D.															22e. ADDRESS 5409 Riverdale Rd., Riverdale, Md. 20840									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Burial					11/15/68					Ft Lincoln Cemetery					Colmar Manor Pro Geo Md.									
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE				
F. Gasch's Sons Hyattsville, Md.										DATE NOV 18 1968										f Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Martha			Middle Jane			Last Stevens		
3. SEX Female			4. RACE Negro			5. DATE OF BIRTH June 9, 1910			2a. DATE OF DEATH Month November Day 29 Year 1968		
7a. BIRTHPLACE (State or foreign country) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Separated			9. COUNTY OF DEATH Prince Georges		
10. CITY OR TOWN OF DEATH Glenn Dale			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic			12b. KIND OF BUSINESS OR INDUSTRY -		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.			13b. COUNTY Washington			13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Henry Middle Taylor Last Taylor			15. MOTHER'S MAIDEN NAME First Hattie Middle Watkins Last Watkins			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown No			16b. SOCIAL SECURITY NO 578-28-0420		
17. INFORMANT Decedent			Address			13e. STREET AND NUMBER 1444 Harvard Street N.W.					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia and bilateral bronchopneumonia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
DUE TO, OR AS A CONSEQUENCE OF (b) Urinary tract infection										years	
DUE TO, OR AS A CONSEQUENCE OF (c) Osteoarthritis, multiple joints										years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) Arteriosclerotic heart disease; obesity											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 9/25/68 , to 11/29/68 , that (X) (we) last saw the deceased alive on 11/29/68 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.											
22b. SIGNATURE <i>Moe Weiss</i>			DEGREE M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 11/29/68		
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.			22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland								
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) Burial			23b. DATE 12/1/68			23c. NAME OF CEMETERY OR CREMATORY Leesburg			23d. LOCATION (City or Town) County (State) Leesburg Loudoun VA		
24. FUNERAL DIRECTOR Jyson Wheeler Funeral Home			25a. REC'D BY REGISTRAR DEC 4 1968			25b. REGISTRAR'S SIGNATURE <i>William C. ...</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

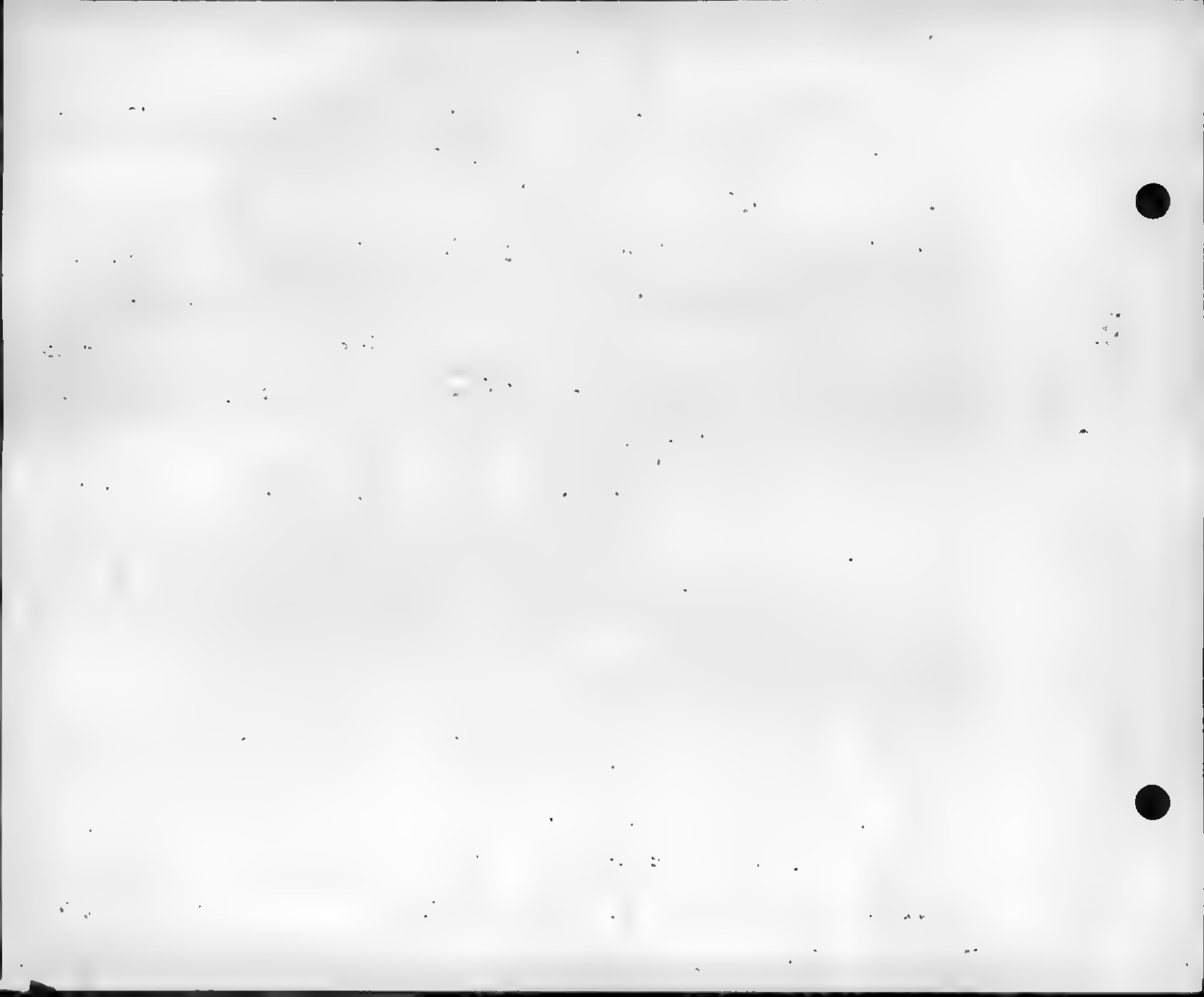
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1044

1. DECEASED-NAME (Type or print) First Middle Last <i>Ruth A. Streeter</i>			2a. DATE OF DEATH Month Day Year <i>Nov. 25 1968</i>			2b. HOUR <i>2:40 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Oct. 25, 1898</i>		6. AGE (In years lost birthday) <i>70</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince Georges</i> Md.	
10. CITY OR TOWN OF DEATH <i>Hyattsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hyattsville Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Sil. Spr.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <i>August Spiekerman</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Emily Maddox</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) <i>No</i>		16b. SOCIAL SECURITY NO <i>579-22-4444</i>		17. Informant's name Address <i>Walter Streeter 614 Sligo Avenue, S.S., Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Brain tumor - inoperable</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>237X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>237X</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9 mo. 5</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Parkinson's disease; Pericardial calcification</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, etc.) <i>Office building, etc.</i>		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>September, 1968</i> , to <i>Nov 25, 1968</i> , that (I) (we) last saw the deceased alive on <i>November 19, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Harold W. Draper, M.D.</i>				22c. DATE SIGNED <i>26 November 68</i>			
22d. PHYSICIAN'S NAME (Type) <i>HAROLD W. DRAPER, M.D.</i>				22e. ADDRESS <i>9801 GEORGIA AVE. S. Lee Spring</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>-11-27-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges, Maryland</i>	
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</i>				25a. REC'D BY REGISTRAR DATE <i>NOV 29 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH MATED		2b HOUR	
James Francis Sullivan						11-20-68 19		4:58pm	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS DAYS	8 UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD		2d HOUR	
Male	White	1-31-1920	48 YRS			11 20 68 19		5:20pm	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Prince George's Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Riverdale			Leland Hospital			bartender			
13a USUAL RESIDENCE (Where deceased lived, if not institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Maryland			Prince George's		Adelphi		2211 Tecunseh Street		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
James Sullivan			Margaret Pfiffer						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS				
Yes			7111		Eleanor Sullivan - above address (Wife)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Laceration of brain</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>Skull fracture</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Trauma - auto accident</u>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A M		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			4:55pm 11-20- 19 68		Driver of car involved in collision.				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State					
		U.S. Rt.1 near Contee Road, Laurel, Prince George County, Maryland							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED	
			John Kehoe MD Riverdale, Md.					11-21-68	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		11/23/68		Columbia Gardens Cem.		Arlington, Va.			
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. Address: St. Rainier, Maryland					25a. REC'D BY REGISTRAR DATE NOV 25 1968		25b REGISTRAR'S SIGNATURE Charles Judge		

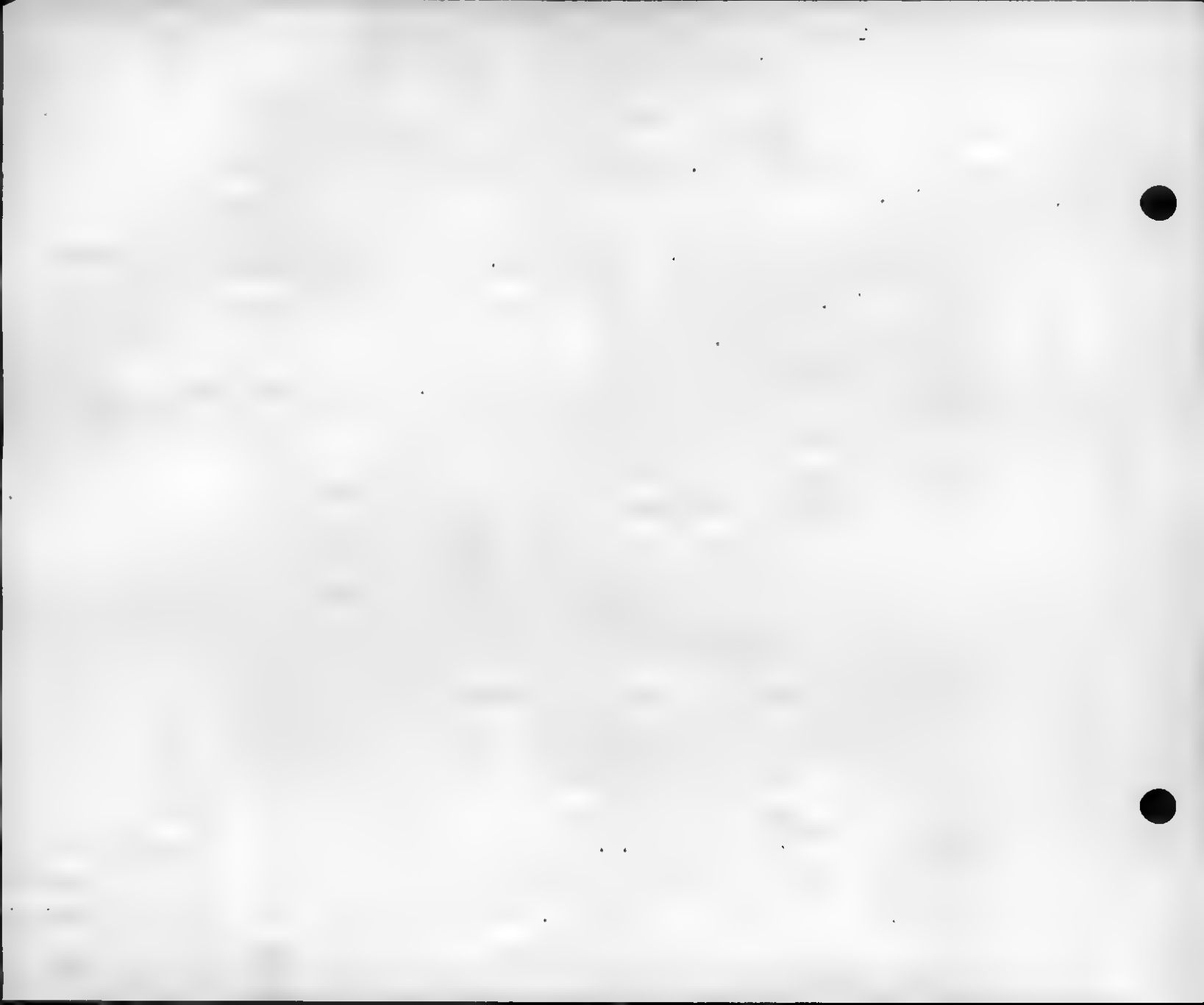


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 11-3-68. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1643? DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
1 DECEASED NAME (Type or Print)			First Opal			Middle Pope			Last Tanner			2a DATE KNOWN OF DEATH ESTIMATED Month 10 Day 3 Year 1968			2b HOUR am 1:00				
3 SEX F		4 RACE W		5 DATE OF BIRTH 5 Oct. 1909		6 AGE (in years last birthday) 59 YRS		IF UNDER YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month 11 Day 3 Year 1968			2d HOUR am 10:07				
7a BIRTHPLACE (State or foreign country) Miss.				7b CITIZEN OF WHAT COUNTRY? U S A				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Prince George Md							
10 CITY OR TOWN OF DEATH Cheverly				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hosp.				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House wife				12b KIND OF BUSINESS OR INDUSTRY Own Home							
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Miss.				13b COUNTY Union				13c CITY OR TOWN New Albany				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e STREET AND NUMBER New Highway 15			
14 FATHER'S NAME First Middle Last Charles A. Pope				15 MOTHER'S MAIDEN NAME First Middle Last Mattie B Short															
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes No or unknown) No				16b SOCIAL SECURITY NO				17. INFORMANT ADDRESS Arthur C. Tanner same as 13											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 3919 Heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Rheumatic valvular heart disease over 20 yrs. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 4142																			
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21a INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State											
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b DATE SIGNED 11-3-68											
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b DATE 11/6/68				23c NAME OF CEMETERY OR CREMATORY Vista Mor. Park Cemetery New Albany Union Mississippi				23d LOCATION (City or Town) (County) (State)							
24 FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland				ADDRESS				25a REC'D BY REGISTRAR DATE NOV 6 1968				25b REGISTRAR'S SIGNATURE Charles Judge							

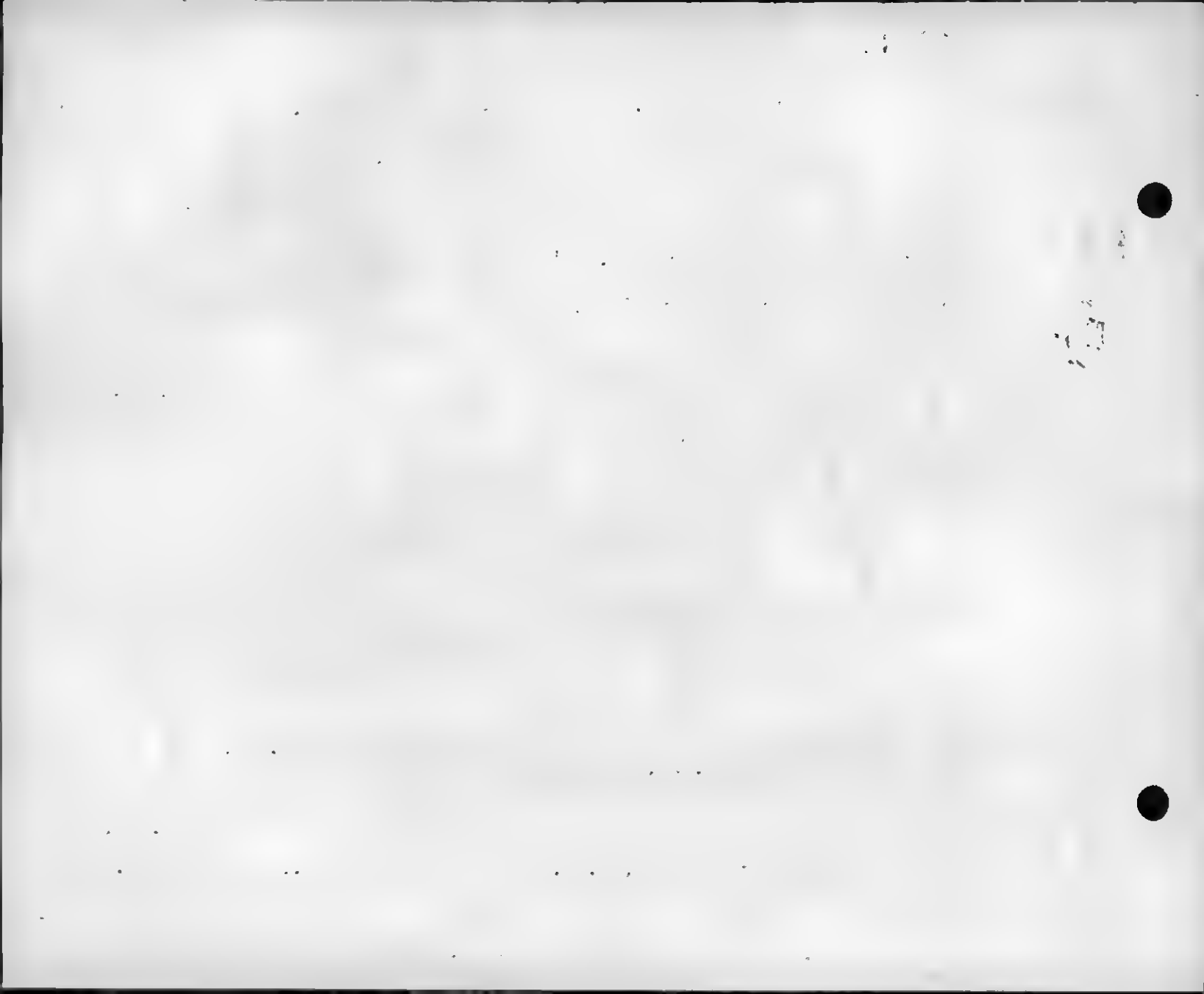


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 45M-1-69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Joseph		D.		Tevis		Nov.		Month 26, Day 1968		Year 5:45AM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Caucasian		August 19, 1907		61 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Pa		U S A				Prince George's				Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Cheverly		Prince Geo. Gen'l Hospital		Book Binder		U S Gov't					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INS OF CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Maryland		Prince George's		Chillum				5803 Sargent Road			
14. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
William Tevis								Lillian Skelton			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
no				168 01 8779		Mollie S Tevis		Hyattsville, Md.			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Pneumonia</u>										2 months	
403 X DUE TO, OR AS A CONSEQUENCE OF <u>Chronic Hepatitis</u>										10 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
DUE TO, OR AS A CONSEQUENCE OF <u>Generalized Arteriosclerosis</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
170 X											
9a DATE OF OPERATION		9b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) XXXXXX attended the deceased from <u>Jan</u> , 19 <u>65</u> , to <u>Nov. 26</u> , 19 <u>68</u> , that (I) xxx last saw the deceased alive on <u>Nov. 26</u> , 19 <u>68</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) xxx (did) not view the body after death.											
22b SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED					
22d PHYSICIAN'S NAME (Type)		22e ADDRESS				Nov. 26, 1968					
Ohannes Sahakyan, M. D.		6001 Landover Rd., Cheverly, Md. 20785									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		Nov 30, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
F. Gasch's Sons		Hyattsville, Md.		DEC 2 1968		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16439

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16453

1. DECEASED-NAME (Type or print) First Middle Last <i>Whitley G Thayer</i>			2a. DATE OF DEATH Month Day Year <i>11 11 68</i>			2b. HOUR <i>2:40 PM</i>	
3. SEX <i>Male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>5-21-03</i>		6. AGE (In years last birthday) <i>65 YRS.</i>	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>P.G.</i>	
10. CITY OR TOWN OF DEATH <i>Clinton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Clinton Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>retired auto mechanic</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Auto</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Clinton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>6749 Colonial La.</i>		14. FATHER'S NAME First Middle Last <i>George Thayer</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Eliza J. Smith</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>Yes</i>		16b. SOCIAL SECURITY NO		17. INFORMANT <i>Madalin J. Thayer</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>109 MYOCARDIAL INFARCTION</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>HIT CVD & ANGINA</i> (b) <i>109</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>LINKED FROM DR. ALAN SCHWARTZMAN</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i> <i>10 years</i>	
PART 2. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201 Obesity</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>11/11/68</i> to <i>11/11/68</i> , that (I) (we) last saw the deceased alive on <i>11/11/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert W. Merkle, M.D.</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>11/11/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>ROBT. W. MERKLE, M.D.</i>				22e. ADDRESS <i>CLINTON, MARYLAND</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11-11-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland Pr. Geo. Md.</i>	
24. FUNERAL DIRECTOR <i>Wilhelm</i>				25a. REC'D BY REGISTRAR <i>Suitland Md.</i>		25b. REGISTRAR'S SIGNATURE <i>NOV 18 1968</i>	



16440

16454

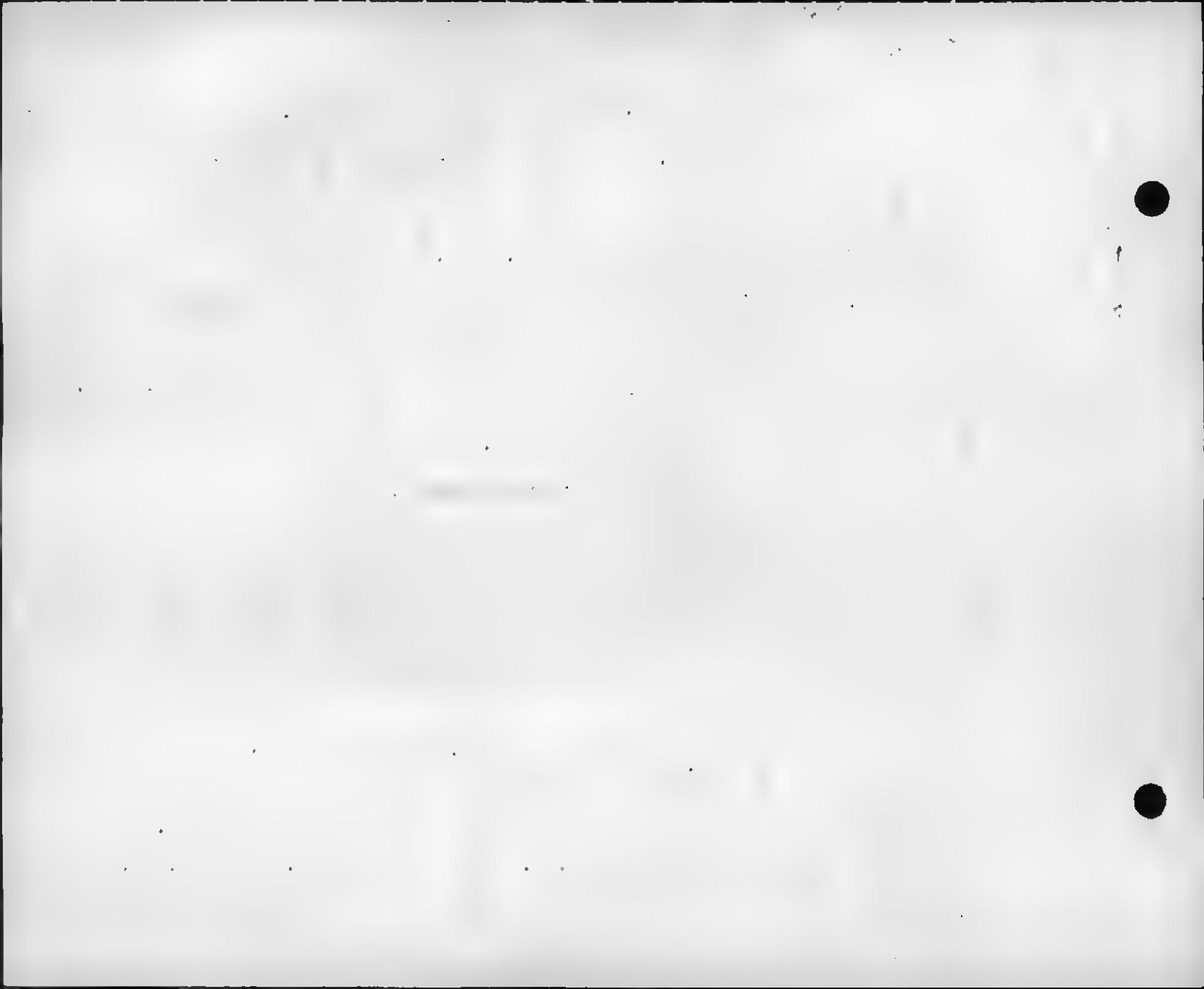
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Debbie A. Thomas			20. DATE OF DEATH Month Nov. Day 30 Year 68			2b. HOUR 5:18PM				
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH 09-27-68		6. AGE (In years last birthday) 2 YRS.		IF UNDER 1 YEAR MONTHS 3 DAYS - HOURS - MIN. -		
7a. BIRTHPLACE (State or foreign country) Md Va.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.				
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. CITY OR TOWN Prince Georges Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 702 Chaney Drive			
14. FATHER'S NAME First Middle Last Lewis G Thomas				15. MOTHER'S MAIDEN NAME First Middle Last Louise Raines						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. ---		17. INFORMANT Address Lewis G Thomas Takoma Park, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest, Acute 4x0 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Secondary Bronchopneumonia, Left Lung DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (the hospital) attended the deceased from Nov. 30, 1968 , to Nov. 30, 1968 , that (I) (we) last saw the deceased alive on Nov. 30, 1968 , and that in my (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Bertha Van Gelderen</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Dec. 2, 1968			
22d. PHYSICIAN'S NAME (Type) Bertha Van Gelderen, M. D.					22e. ADDRESS 3001 Cheverly Ave., Cheverly, Md. 20785					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec 4, 1968		23c. NAME OF CEMETERY OR CREMATORY Zoan Church Cemetery			23d. LOCATION (City or Town) Spotsylvania County Va		(County) (State)	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR DATE DEC 4 1968		25b. REGISTRAR'S SIGNATURE <i>W. C. Lewis</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



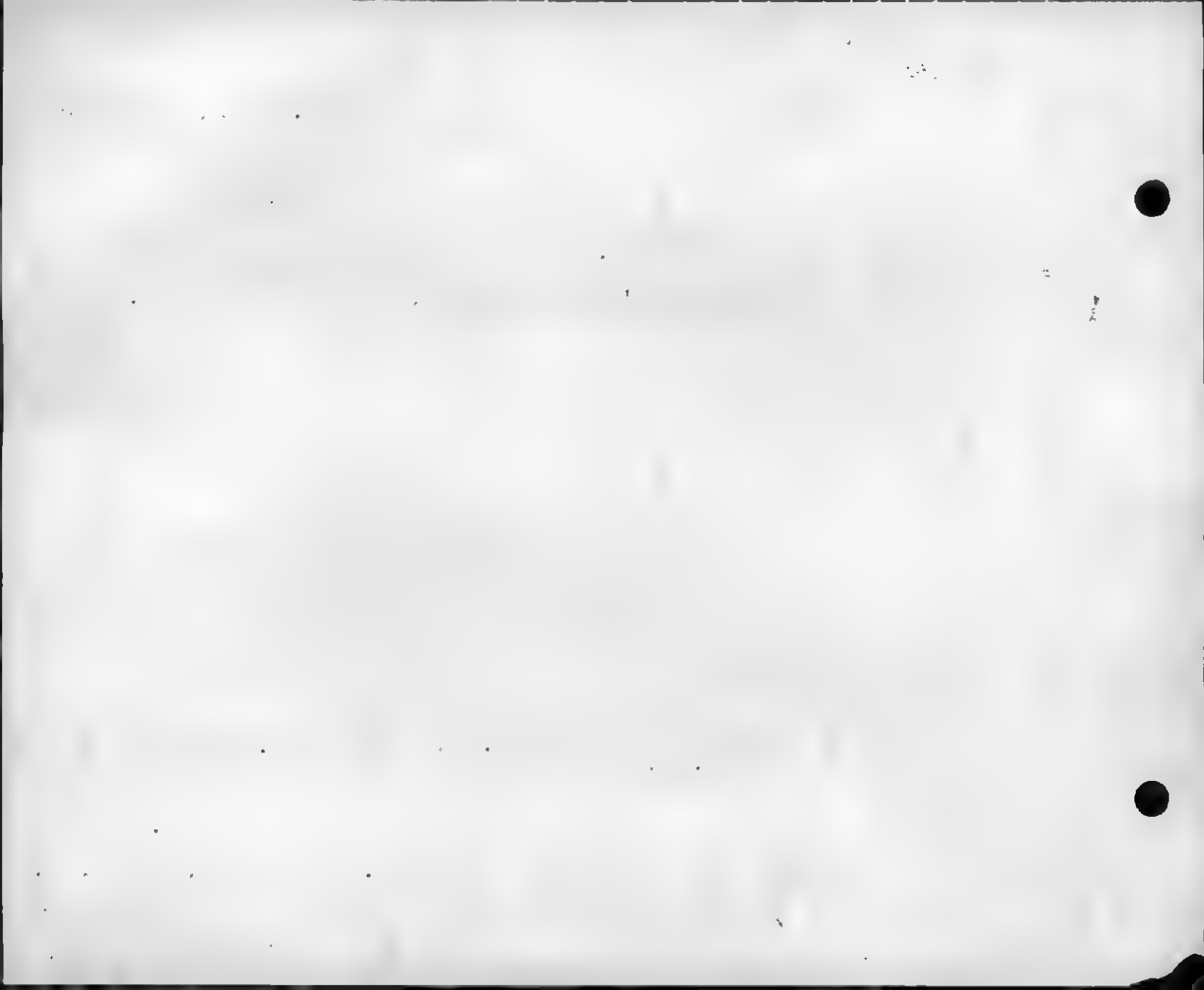
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS A15
45M - 66

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16441 Item 23a, Film 407 12/9/68 km											
10450 CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR		
James Thomas						Nov. 25, 1968			3:10PM		
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		Negroid		6- 1875		93 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md		U.S.A.				Prince George's		Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Geo. Gen'l Hospital			Farmer			on Farm		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Prince George's			Mitchellsville			Route #2, Box 27.		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
James Thomas			Mary West								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
No			-			John Thomas			Bowie Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 011.9 Tuberculosis											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home farm street factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that the (this hospital) attended the deceased from Nov. 10, 1968, to Nov. 25, 1968, that we (we) last saw the deceased alive on Nov. 25, 1968, and that in our (our) opinion death occurred on the date and hour and from the causes stated above, that (we) (did) not view the body after death.											
22b SIGNATURE		22c DATE SIGNED									
Dr. Arnold G. Brody		Nov. 25, 1968									
22d PHYSICIAN'S NAME (Type)		22e ADDRESS									
Dr. Arnold G. Brody		Prince Geo. Gen'l Hospital, Cheverly, Md.									
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
B. REMOVAL		11-30-68		Hesperomony		Highland Park Md					
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
H.S. W. Washington		4925 Branch 6		DEC 2 1968		Charles Judge					

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in the margin. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100. Page 5 may be retained for your files.

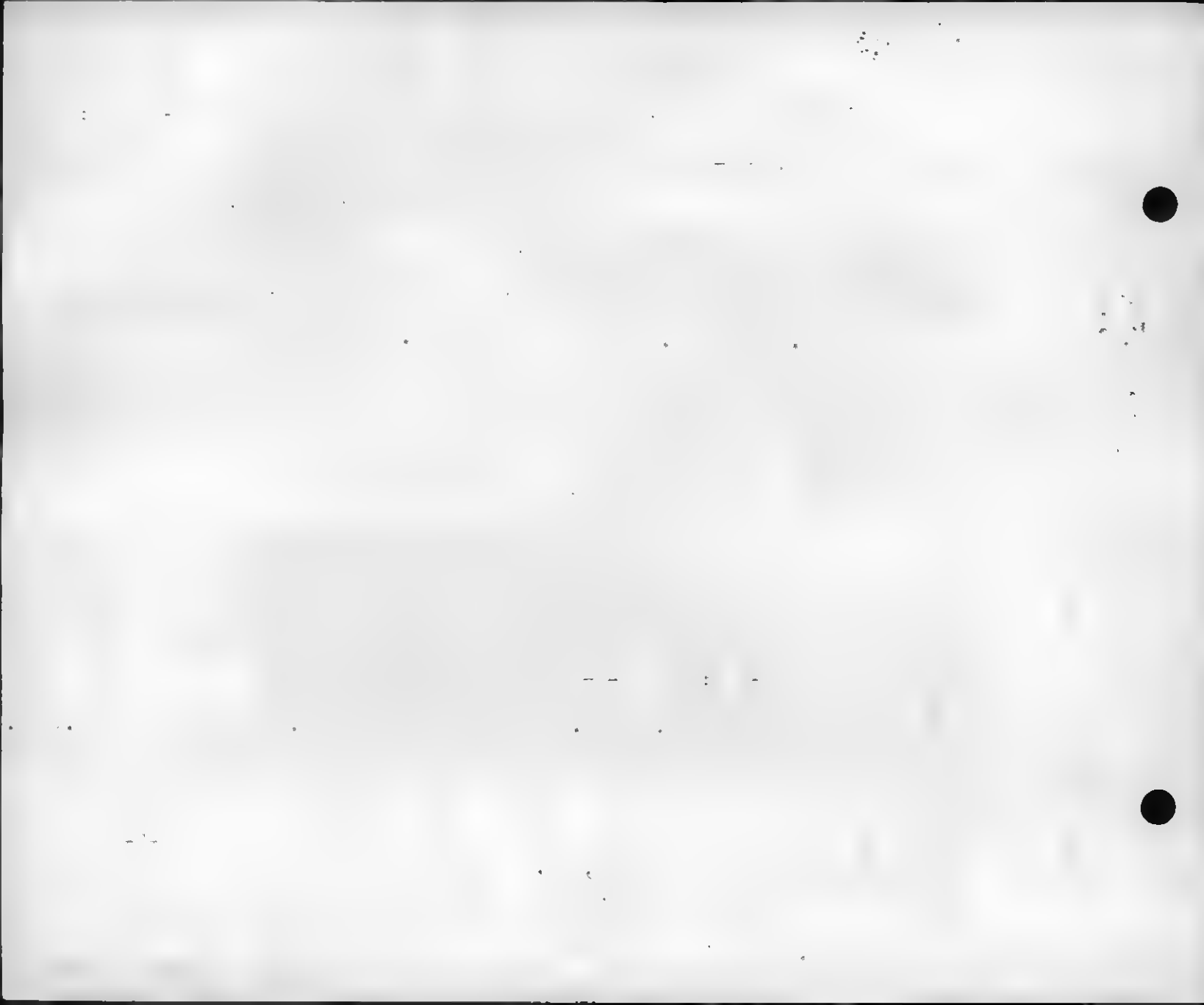
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16442

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16450

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF EST. - DEATH MATED			2b. HOUR		
William J. Thomas Jr.						11-6-68			12:45am M		
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	11-17-1946	21 YRS					11-6-68		3:40am M	
7a. BIRTHPLACE (State or foreign country) DC			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol give street address) Prince George Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Auto		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN Forestville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last William J. Thomas Sr.			15. MOTHER'S MAIDEN NAME First Middle Last Mary G. Barney			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. Unknown		
17. INFORMANT (Father) William J. Thomas Sr.,			ADDRESS Same as # 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral hemothorax DUE TO, OR AS A CONSEQUENCE OF Multiple rib fractures (b) From trauma - auto accident DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR AM 3:40am 11-6-68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Pedestrian struck by car					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Suitland Road, 125ft. west of Meadow View Dr., Prince George Co., Md.			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED 11-7-68					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial			23b. DATE 11-9-68			23c. NAME OF CEMETERY OR CREMATORY Washington National Cem.			23d. LOCATION (City or Town) (County) (State) Suitland, PG Maryland		
24. FUNERAL DIRECTOR: Wilhelm Funeral Home 4308 Suitland Rd. SE, Suitland, Maryland						25a. REC'D BY REGISTRAR DATE NOV 18 1968			25b. REGISTRAR'S SIGNATURE Charles J. Jasso		



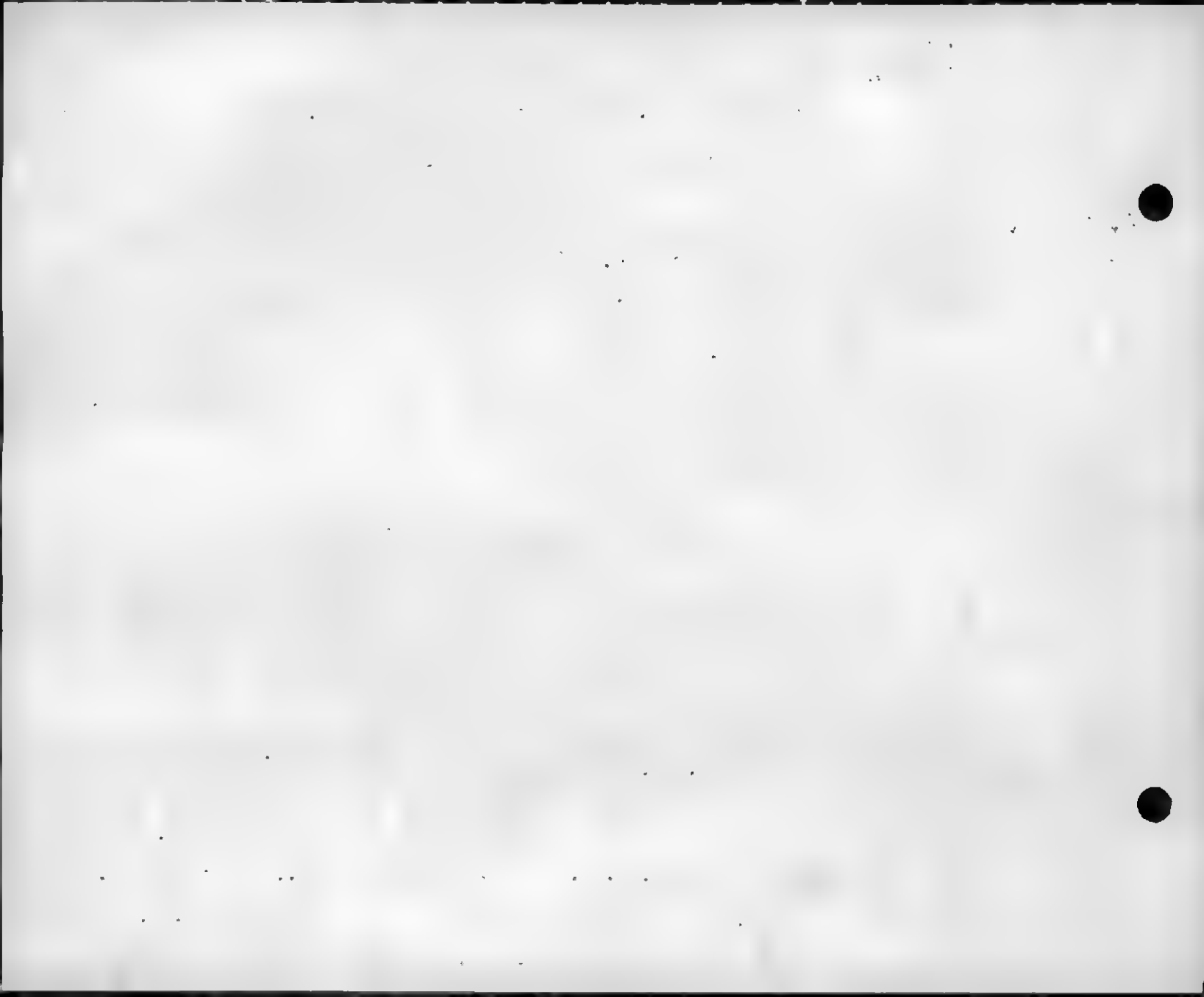
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cardiomegaly, Chronic Hypertension, Atherosclerosis

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
1. DECEASED NAME (Type or print)		First Thomas		Middle A.		Last Thornhill		2a. DATE OF DEATH Nov. Month 21, Day 1968 Year		2b. HOUR 5:15AM
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH May 2, 1968		6 AGE (in years last birthday) YRS. 6		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Texas		7b. CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md				
10. CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) --		12b. KIND OF BUSINESS OR INDUSTRY				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Hyattsville		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5833 33rd Place		
14 FATHER'S NAME Thomas J. Thornhill		First Middle Last		15 MOTHER'S MA DEN NAME Isabella Santini		First Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. -- -- -- --		17 INFORMANT Thomas J Thornhill		Address Hyattsville, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory failure</i> 1467 DUE TO, OR AS A CONSEQUENCE OF <i>Chronic heart disease (Coronary Arteriosclerosis)</i> (b) DUE TO, OR AS A CONSEQUENCE OF <i>Chronic pneumonia, Pulmonary emphysema</i> (c) <i>Partial Cleft palate</i> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to Nov. 21, 1968, that (I) (we) last saw the deceased alive on Nov. 21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE <i>Bernardo Alvarado</i>		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Nov. 21, 1968				
22d. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M. D.		22e. ADDRESS 6201 Riverdale Rd., Riverdale, Md. 20840								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/23/68		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION (City or Town) Washington D. C.		(County)		(State)
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 25 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

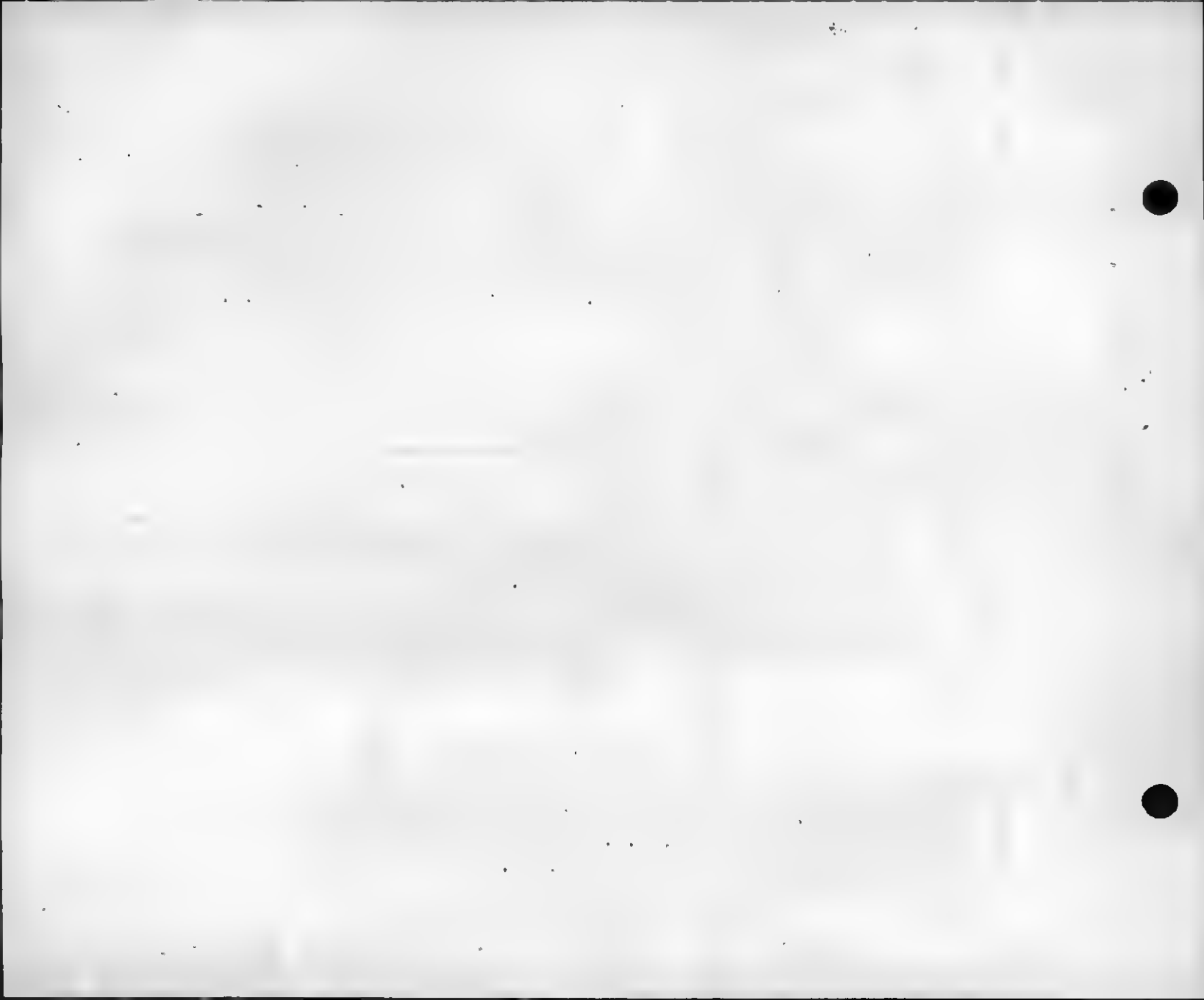
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16446

1645

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 11-22-68 1972:30am			2b. HOUR		
Hazel			Elsie			Trainum					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Female		White		4-16-1923		45 YRS					
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
Md				U S A				9. COUNTY OF DEATH Prince George's Md			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			
Riverdale				Leland Hospital				Clerk Dep			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) - STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland				Prince George's Mt. Rainier						13e. STREET AND NUMBER 3513 R.I. Avenue	
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last					
Albert B Ridgeway						Susie A Vermillion					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO						16b. SOCIAL SECURITY NO 218 24 0482		17 INFORMANT ADDRESS Oscar J. Trainum Mt Rainier, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure										Min.	
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease										Unknown	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last 4200 (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus-known over 3 yrs.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-22-68			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Nov 25, 1968		23c. NAME OF CEMETERY OR INTERMENT Epiphany Episcopal Church		23d. LOCATION (City or Town) (County) (State) Forestville Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gaseh's Sons Hyattsville, Md.						25a. REC'D BY REG STRAR DATE NOV 27 1968		25b. REG STRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please re-approve carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

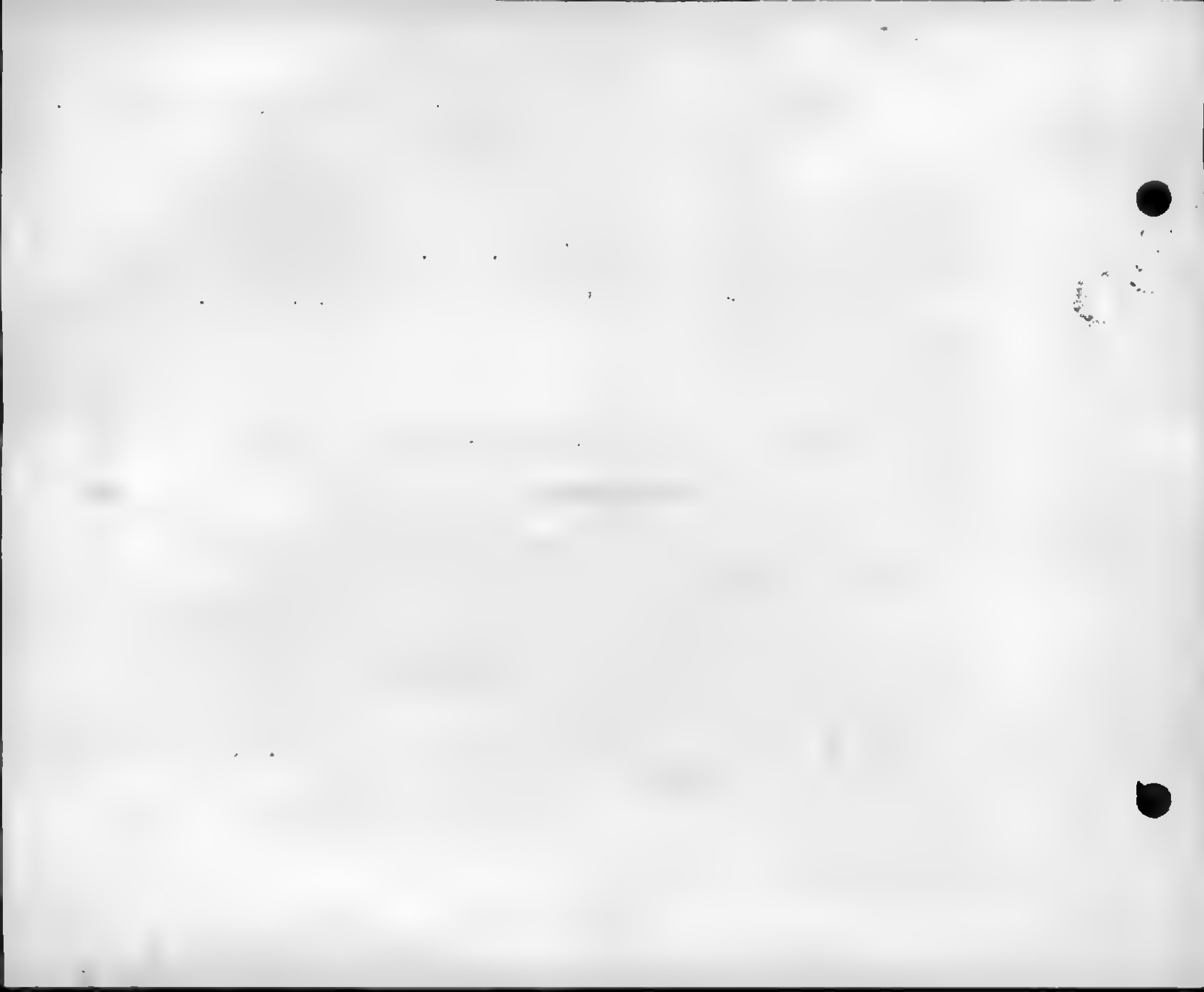
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16445

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16459

1 DECEASED NAME (Type or print)		First George		Middle		Last Trower		2a DATE OF DEATH Month November Day 9, Year 1968		2b HOUR 1:05AM	
3 SEX Male		4 RACE / Colored		5 DATE OF BIRTH 6/29/05		6 AGE (n years last birthday) 63 YRS		7 JUNIOR 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Va.		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md					
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Janitor		12b KIND OF BUSINESS OR INDUSTRY					
13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b COUNTY Prince George's		13c CITY OR TOWN Seat Pleasant		13d INSIDE CITY, LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 6704 F St.			
4 FATHER'S NAME Matthew Trower		First		Middle		Last		15 MOTHER'S MAIDEN NAME Betty ?		First Middle Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		16b SOCIAL SECURITY NO -		17 INFORMANT Florence Howard		Address			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia (organism undetermined) 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Idiopathic Epilepsy										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
19a DATE OF OPERATION None		19b CONDIT ON FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 11/3, 1968, to Nov. 9, 1968, that (I) (we) last saw the deceased alive on November 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Fidel J. Quintana		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 11-9-68					
22d PHYSICIAN'S NAME (Type) FIDEL J. QUINTANA		22e ADDRESS 87.5 FIRST AVE, S. SPRING, MD.									
23a BURIAL, CREMATION, REMOVAL (Specify) 11-15-68		23b DATE		23c NAME OF CEMETERY OR CREMATORY Harmony		23d LOCATION (City or Town) (County) (State) Highland Park Md					
24 FUNERAL DIRECTOR H.S. Washington		ADDRESS 4945 Dun Gue NE		25a REC'D BY REGISTRAR DATE NOV 14 1968		25b REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE HEALTH DEPT.

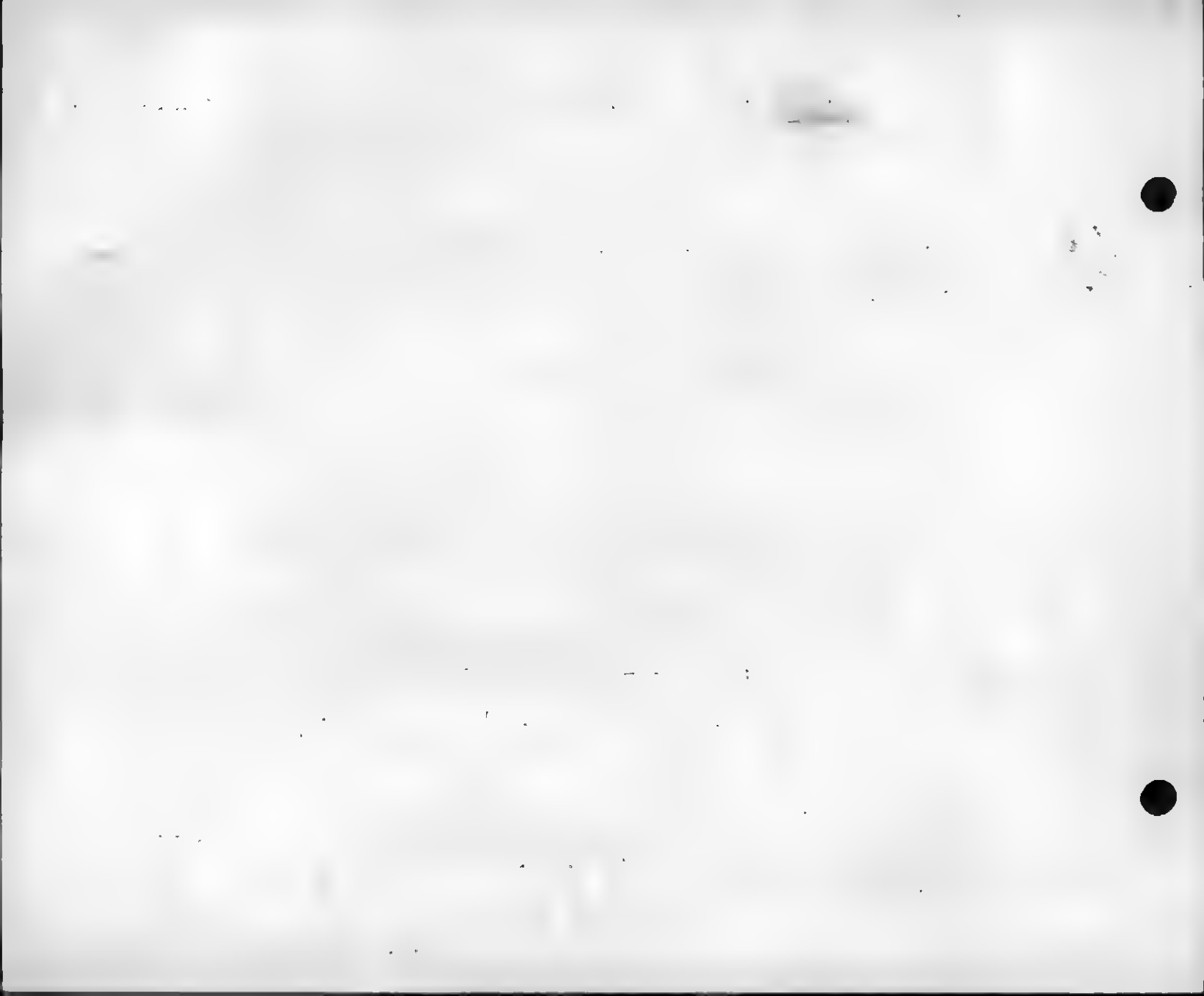
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16448

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
Unidentified			Negro			Male			11-4-68			1968 6:03pm			
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		F UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			
Male		Negro		unknown		YRS.		MONTHS		DAYS		Month Day Year			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. COUNTY OF DEATH			
												Prince George's Md.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly				Prince George Hospital											
13a. USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission)				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
STATE unknown				unknown				unknown				YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO			
First Middle Last				First Middle Last				(Yes, no, or unknown) (If yes give war or dates of service)				17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain															
DUE TO, OR AS A CONSEQUENCE OF Trauma - struck by car															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)															
1114															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
				6:00pm 11-4-1968				Pedestrian struck by car							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town		County	
				Old Fort Road, Prince George's County, Maryland											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
John Kehoe MD				Riverdale, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				11-7-68			
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
				11-26-68				V. J. and M. J. Kehoe				Baltimore, Md.			
24. FUNERAL DIRECTOR								ADDRESS				25a. REC'D BY REG. STRAR			
												25b. REGISTRAR'S SIGNATURE			
												Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

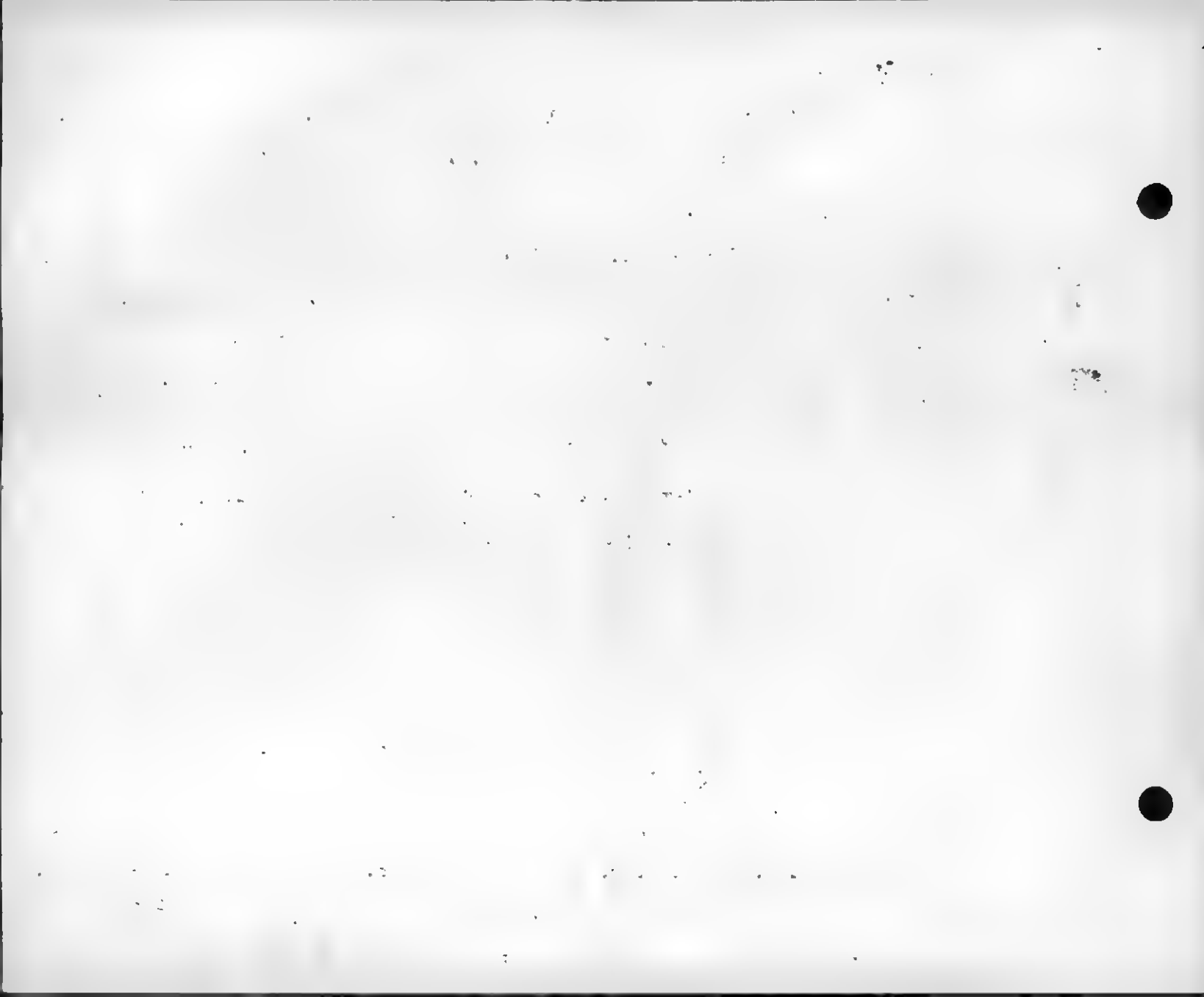
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16447

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Eleanor S. Walker			2a. DATE OF DEATH Month Day Year Nov. 17, 1968			2b. HOUR 11:28 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 4/2/02		6. AGE (In years last birthday) 66 YRS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Landover		13d. INSIDE CITY, W.H.T.S? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3410 Dodge Park Road		14. FATHER'S NAME First Middle Last James W. W. America		15. MOTHER'S MAIDEN NAME First Middle Last Fannie E. Fillius			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO (If yes give year or dates of service) None		17. INFORMANT Mrs Carolyn F. Heath		Address 3410 Dodge Park Rd Landover, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute thrombotic occlusion of left coronary artery. 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic heart disease, severe, with DUE TO, OR AS A CONSEQUENCE OF old myocardial infarction. (c) Congestive heart failure. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 Diabetes Mellitus.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from Nov. 17, 1968 , to Nov. 17, 1968 , that (X) (we) last saw the deceased alive on Nov. 17, 1968 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Arnold G. Brody, M. D.		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED Nov. 18, 1968	
22d. PHYSICIAN'S NAME (Type) Arnold G. Brody, M. D.		22e. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Nov. 21, 1968		23c. NAME OF CEMETERY OR CREMATORY Addison Chapel		23d. LOCATION (City or Town) (County) (State) Seat Pleasant, Md	
24. FUNERAL DIRECTOR W. W. CHAMBERS CO		ADDRESS 517 N. 1st St. Wash. D.C.		25a. REC'D BY REGISTRAR DATE NOV 26 1968		25b. REGISTRAR'S SIGNATURE James Judge	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

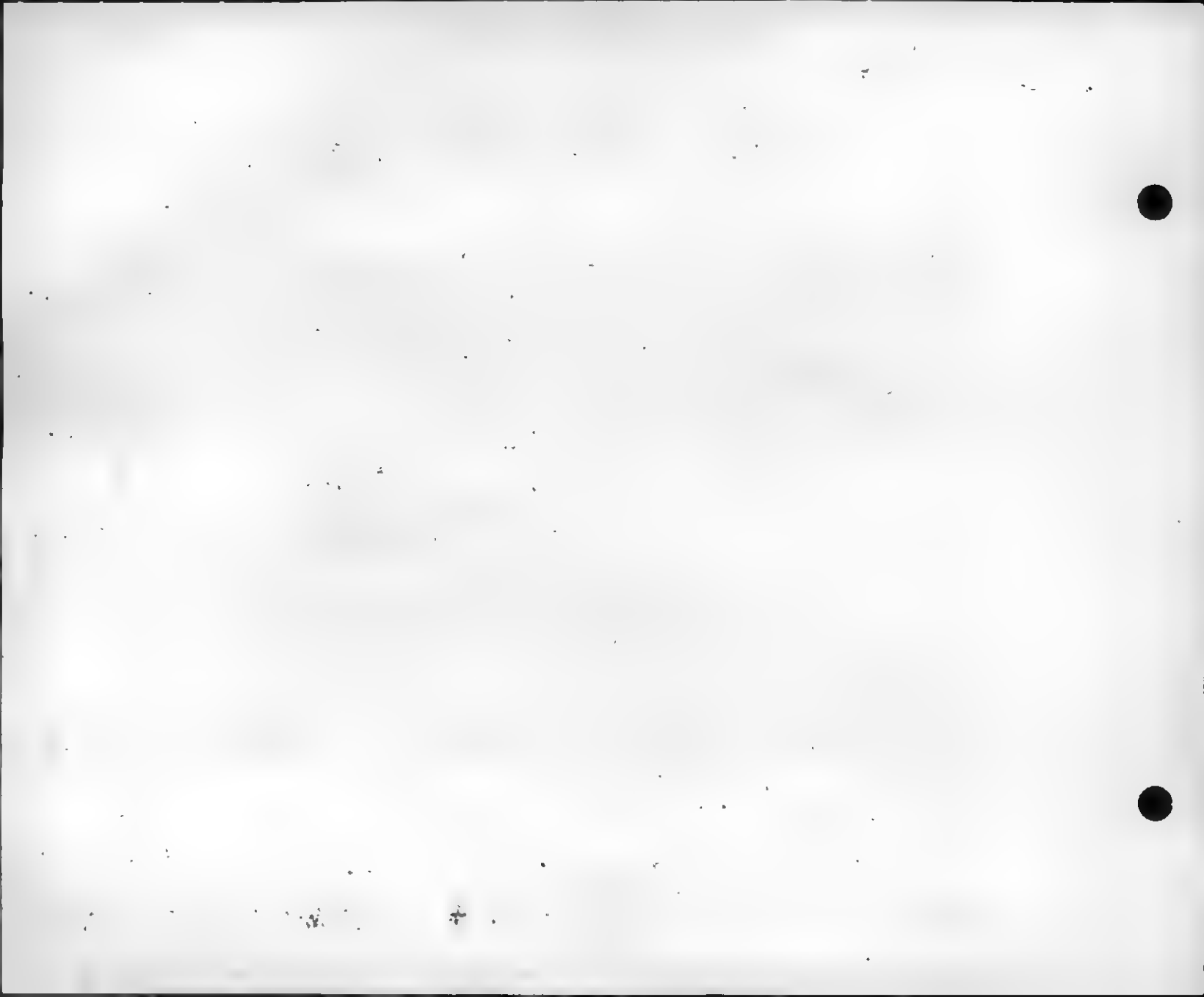
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16448

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Emmett H. Walker			2a. DATE OF DEATH Month 11 Day 6 Year 1968			2b. HOUR 10⁵⁰ AM	
3 SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 10-14-1892		6 AGE (In years lost birth day) 76 YRS	
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.	
10. CITY OR TOWN OF DEATH Greenbelt		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Greenbelt Community Center		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Carpenter		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) STATE MD		13b CITY OR TOWN College Park		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1400 Cherry Hill Rd	
14 FATHER'S NAME First Middle Last Brodie Walker			15. MOTHER'S MAIDEN NAME First Middle Last ELIZABETH BELL			Address 1400 Cherry Hill Rd College Park Md	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown NO		16b. SOCIAL SECURITY NO. 217-03-1974		17. INFORMANT Mrs. Marjorie Walker			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis							2 weeks
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized atherosclerosis							10 years
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus							20 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 260x							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1/8/65 , 19__, to 11/6/68 , 19__, that (I) (we) last saw the deceased alive on 11/3/68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William B. Gunther				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/6/68	
22d. PHYSICIAN'S NAME (Type) DR. WILLIAM B. GUNTHER				22e. ADDRESS 4917 EDGEWOOD RD COLLEGE PARK MD.			
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE 11-9-1968		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d. LOCATION (City or Town) (County) (State) COLMAR MANOR MARYLAND	
24. FUNERAL DIRECTOR W. W. CHAMBERS Co. RIVERDALE, MD				25a. REC'D BY REGISTRAR DATE NOV 12 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 409 MARYLAND STATE DEPARTMENT OF HEALTH
1-23-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18442

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16462

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH Month Day Year				2b. HOUR	
William		Wallace						11-10-68 19 10:00am					
3 SEX	4. RACE	5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		7. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
Male	Negro	AUG. 26, 1934		34 YRS.		MONTHS DAYS		HOURS MIN		11 10 68		10:15am	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
D.C.		U.S.A.				Prince George's						Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY							
Cheverly		Prince George Hospital		LABORER									
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland		Prince George's		Cedar Heights		YES <input type="checkbox"/> NO <input type="checkbox"/>		6420 L Street					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle Last	
Edward		SNYDER						Ruth E. Nichols					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS							
NO				Ruth E. Nichols		6420-L St Cedar Hgts Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY.													
IMMEDIATE CAUSE (a) Cirrhosis of liver													
DUE TO, OR AS A CONSEQUENCE OF													
(b) and acute alcoholism													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
581.1													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH				19 P.M.									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or RFD No City or Town County State					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>													
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				11-11-68					
John Kehoe MD Riverdale, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)					
23a. BURIAL CREMA-ON, REMOVA. (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY					
				11-16-68				HARMONY					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR					
H.S. Washington & Sons				4925 Deane Ave				25b. REGISTRAR'S SIGNATURE					
								NOV 18 1968					

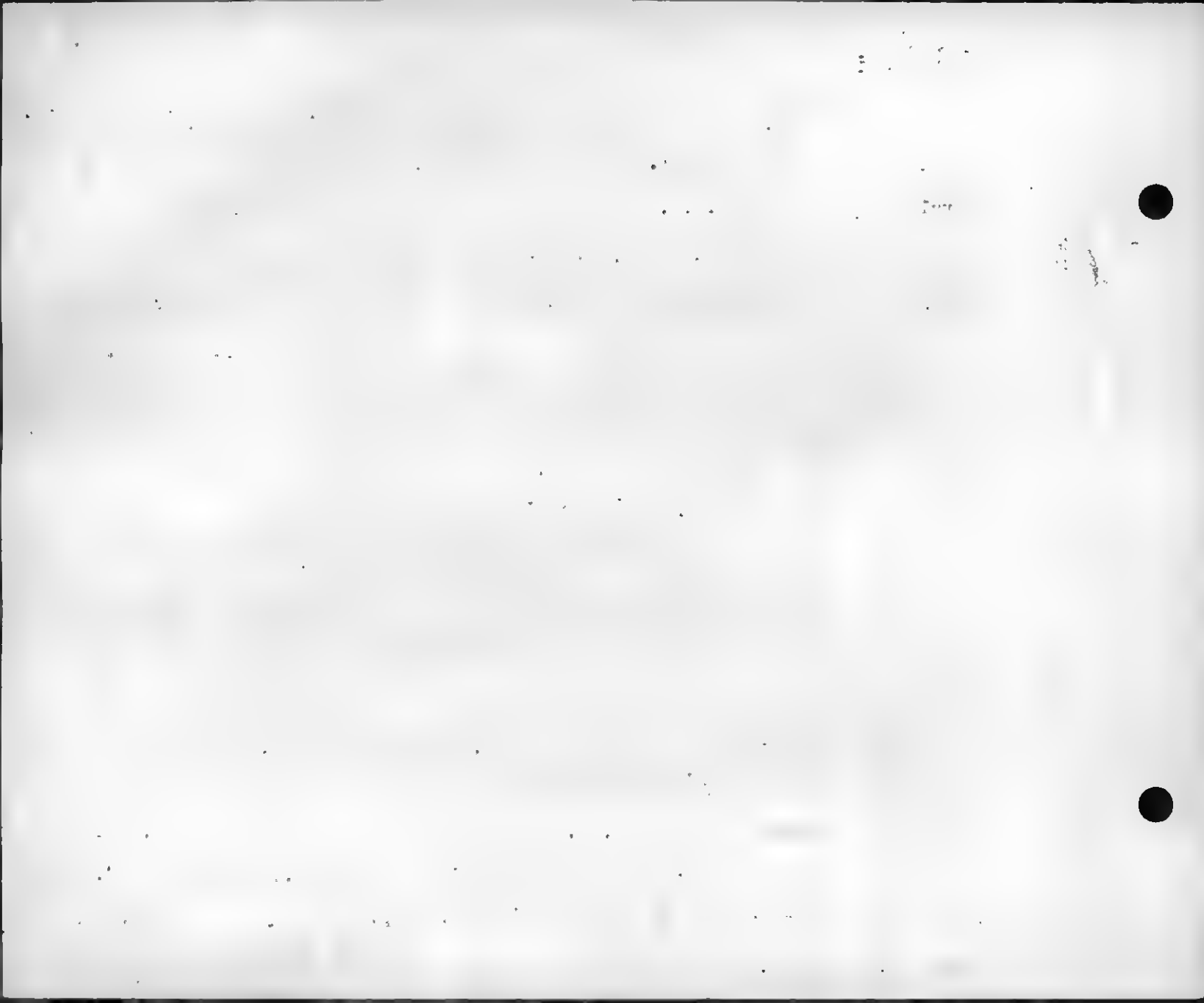


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

<div style="display: flex; justify-content: space-between;"> 16450 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 18238 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div>																	
1. DECEASED NAME (Type or print)			First Baby			Middle Girl			Last Watkins			2a. DATE OF DEATH Month Nov. Day 29 Year 1968			2b. HOUR 10:55 ^A		
3. SEX Female			4-RACE Caucasian			5. DATE OF BIRTH Nov. 28, 1968			6. AGE (In years lost birthday) YRS. —			IF UNDER 1 YEAR MONTHS — DAYS —		IF UNDER 24 HRS HOURS 14 MIN 45			
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's ^{Md}								
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN Bladensburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 5012 57th Avenue					
14. FATHER'S NAME			First Milner			Middle Ross			Last Watkins			15. MOTHER'S MAIDEN NAME First Janice Middle Lee Last Erisman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO. (!! give year or dates of service)			17. INFORMANT Address											
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure																	
7769 DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
(b) U.S. Legion																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) Pneumonia. Pneumonia																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town			County			State		
22a. I certify that (I) (we) attended the deceased from Nov. 28, 1968 to Nov. 29, 1968 , that (I) (we) lost saw the deceased alive on Nov. 29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.																	
22b. SIGNATURE Bernardo Alvarado, M.D. DEGREE														ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Nov. 29, 1968	
22d. PHYSICIAN'S NAME (Type) [Signature]														22e. ADDRESS 6201 Riverdale Rd., Riverdale, Md. 20840			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 12-22-68			23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. Cheverly			23d. LOCATION (City or Town) (County) (State) P.G. Maryland								
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Administrator ADDRESS														25a. REC'D BY REGISTRAR DATE DEC 26 1968		25b. REGISTRAR'S SIGNATURE [Signature]	



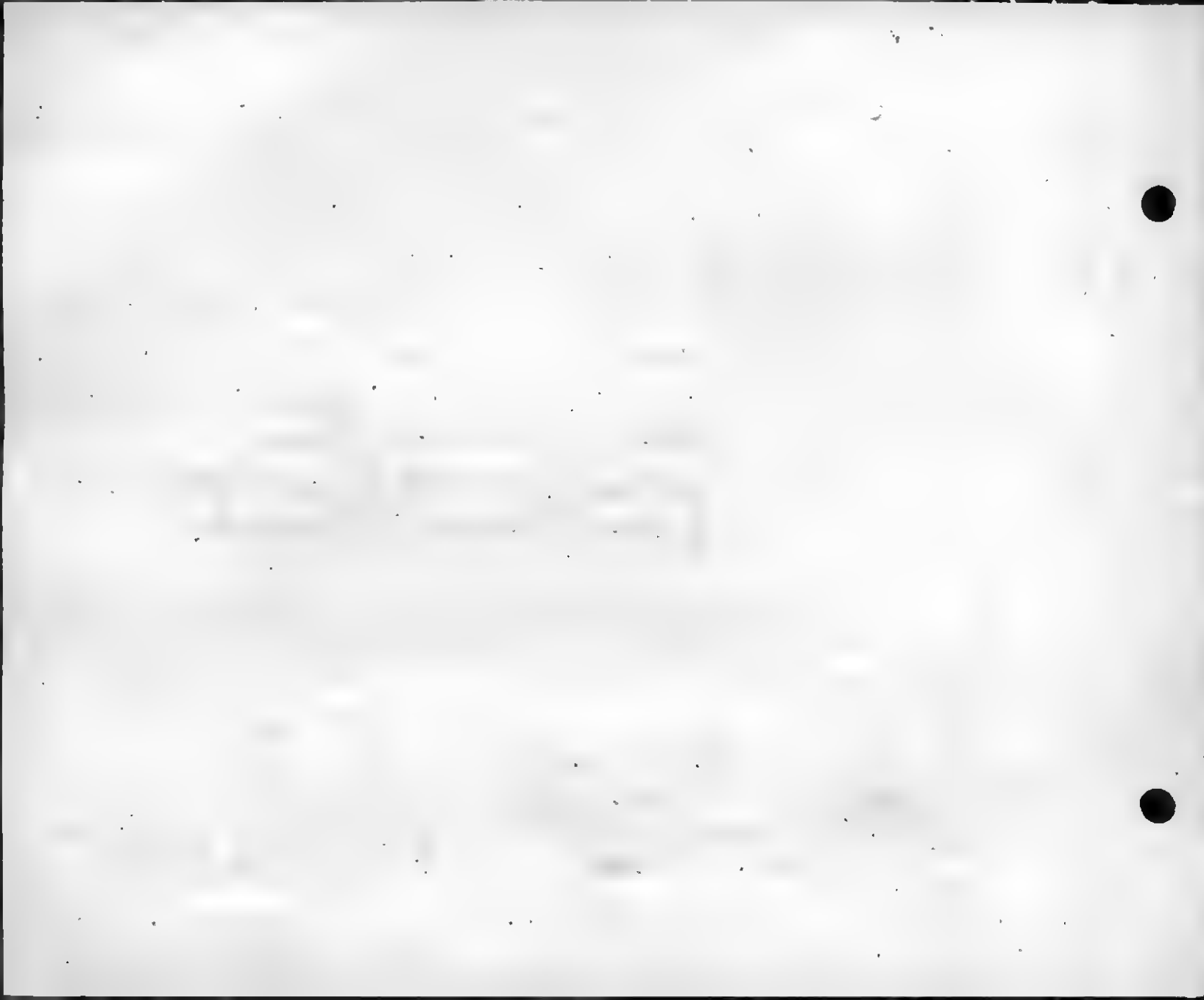
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16451

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1646

1. DECEASED NAME (Type or print) Catherine		First Middle Last Wenzel		2c. DATE OF DEATH Month Day Year November 2 1968		2b. HOUR 3:00 A.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 3-4-87		6. AGE (In years last birthday) 81 YRS	
7a. BIRTHPLACE (State or foreign country) Tennessee		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges County Md.	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Leland Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) Virginia		13b. COUNTY Falls Church		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 808 W. Broad Street	
14. FATHER'S NAME First Middle Last Andrew A. Schatz				15. MOTHER'S MAIDEN NAME First Middle Last Francis Bierlein			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 224-72-3595		17. INFORMANT Address Joseph A. Wenzel - Medical Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Paternal Pulmonary Edema 4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive/arteriosclerotic cerebrovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Thrombosis & R Hemiplegia PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10/14 , 19 65 , to Nov , 19 65 , that (I) (we) last saw the deceased alive on Nov , 19 65 , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W.C. Etienne DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED 11/2/65			
22d. PHYSICIAN'S NAME (Type) W.C. ETIENNE		22e. ADDRESS College Park, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D. C.	
24. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville, Md				25a. REC'D BY REGISTRAR DATE NOV 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16452

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16452

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN <input type="checkbox"/> Month Day Year			2b HOUR
William R. J. White						OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 11-6-68			13:15am M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Male	White	3-17-1896	72 YRS					11 6 68	4:33am M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
New Jersey		USA				Prince George's Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince George Hospital			Ret. Heating Eng.			
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER		
Maryland			Prince George's		Bowie		12612 Killian Lane		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
William					White	Mary			Rahm
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT				
yes			135-05-5835		Mrs. Mary Ellen - 130 Village Way, Bricktown, N.J.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure									minutes
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease									over 5 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
CAUSE OF DEATH			19						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State				
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			11-6-68			
John Kehoe MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
Riverdale, Md.									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE	23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Removal-Burial		11/9/68	St. Catherine's Cemetery Sea Girt			New York			
24 BURIAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Beverly E. Hopping			Beverly E. Hopping			NOV 7 1968		J. Charles Judge	
HOPPING FUNERAL HOME			Annapolis, Md.						



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

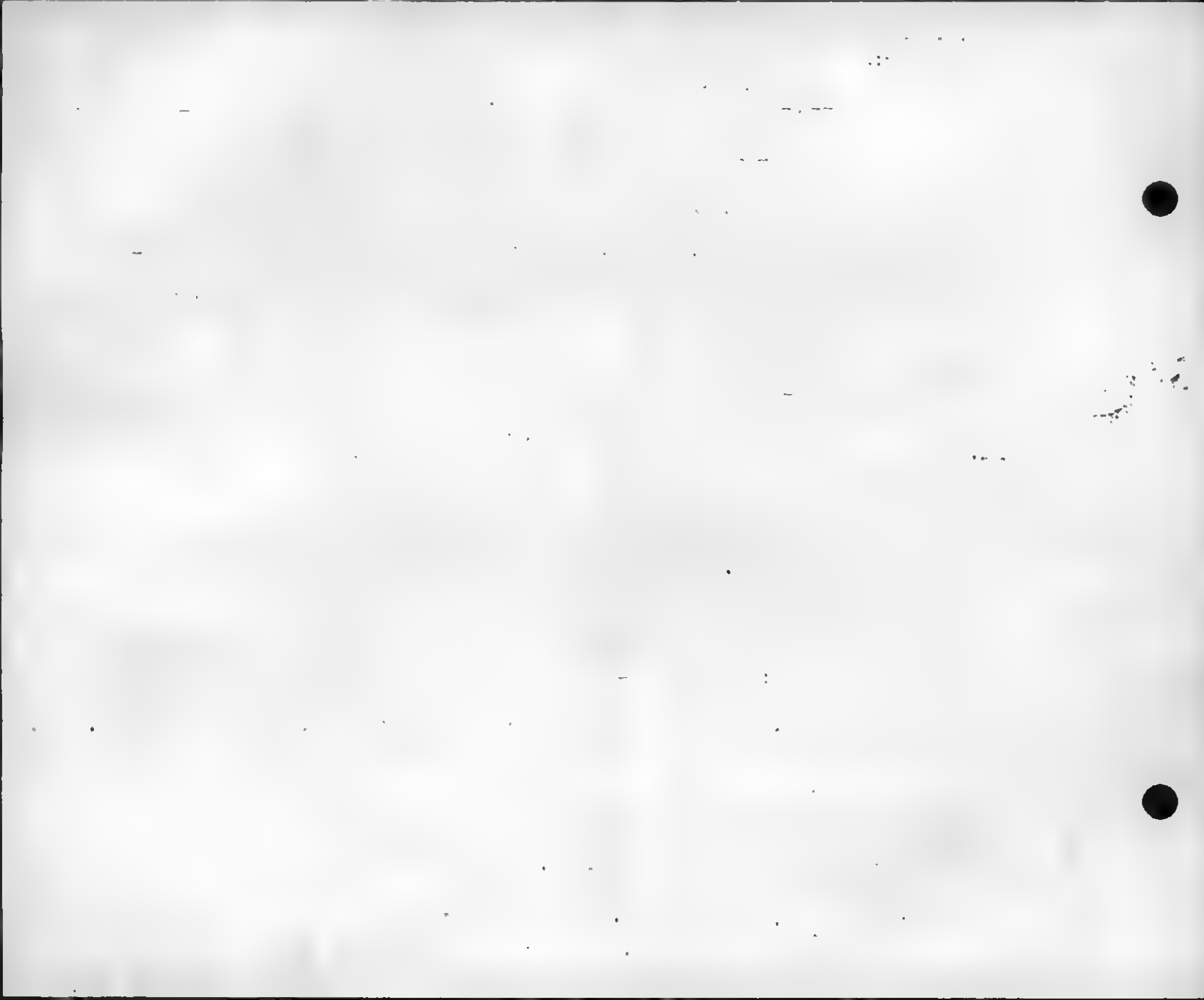
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

16453

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10453

1 DECEASED NAME (Type or Print) First <u>Teruko</u> Middle <u>Whittaker</u> Last <u>Whittaker</u>		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 11-23-68 19:25am		2b. HOUR
3 SEX <u>Female</u>	4 RACE <u>White</u>	5 DATE OF BIRTH <u>9-7-1924</u>	6 AGE (in years last birthday) <u>44</u> YRS	IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>
7a BIRTH-PLACE (State or foreign country) <u>Japan</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Prince George's</u> Md.
10 CITY OR TOWN OF DEATH <u>Cheverly</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Prince George Hospital</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Barber</u>
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before death) <u>Maryland</u> STATE <u>Prince George's</u> COUNTY <u>Hyattsville</u>		13b. INSIDE CITY LIMITS? <u>YES</u>	13c. STREET AND NUMBER <u>8510 Caswell Place</u>	
14. FATHER'S NAME First <u>Eaizamon</u> Middle <u>Fukuno</u> Last <u>Tsuwa</u>		15 MOTHER'S MAIDEN NAME First <u>Tsuwa</u> Middle <u>?</u> Last <u>?</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16b. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Clarence R. Whittaker (above address)</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of brain</u> <u>1120</u> DUE TO, OR AS A CONSEQUENCE OF <u>Trauma - auto accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u> </u> DUE TO, OR AS A CONSEQUENCE OF <u> </u> (c) <u> </u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a. DATE OF OPERATION <u>11-23-68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Driver of car involved in collision with fire truck</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <u>7:22am 11-23-1968</u>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>85th. Ave and Annapolis Road, New Carrollton, Prince George Co., Md.</u>		
21f. LOCATION Street or RFD No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE <u>John Kehoe</u> EXAMINER'S NAME (Type) <u>John Kehoe MD Riverdale, Md.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <u> </u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>11/25/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>	
23d. LOCATION (City or Town) <u>Colman Manor, Md.</u>		23e. REC'D BY REGISTRAR <u>NOV 27 1968</u>		
24. FUNERAL DIRECTOR <u>Harley's Funeral Home Inc.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed, within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

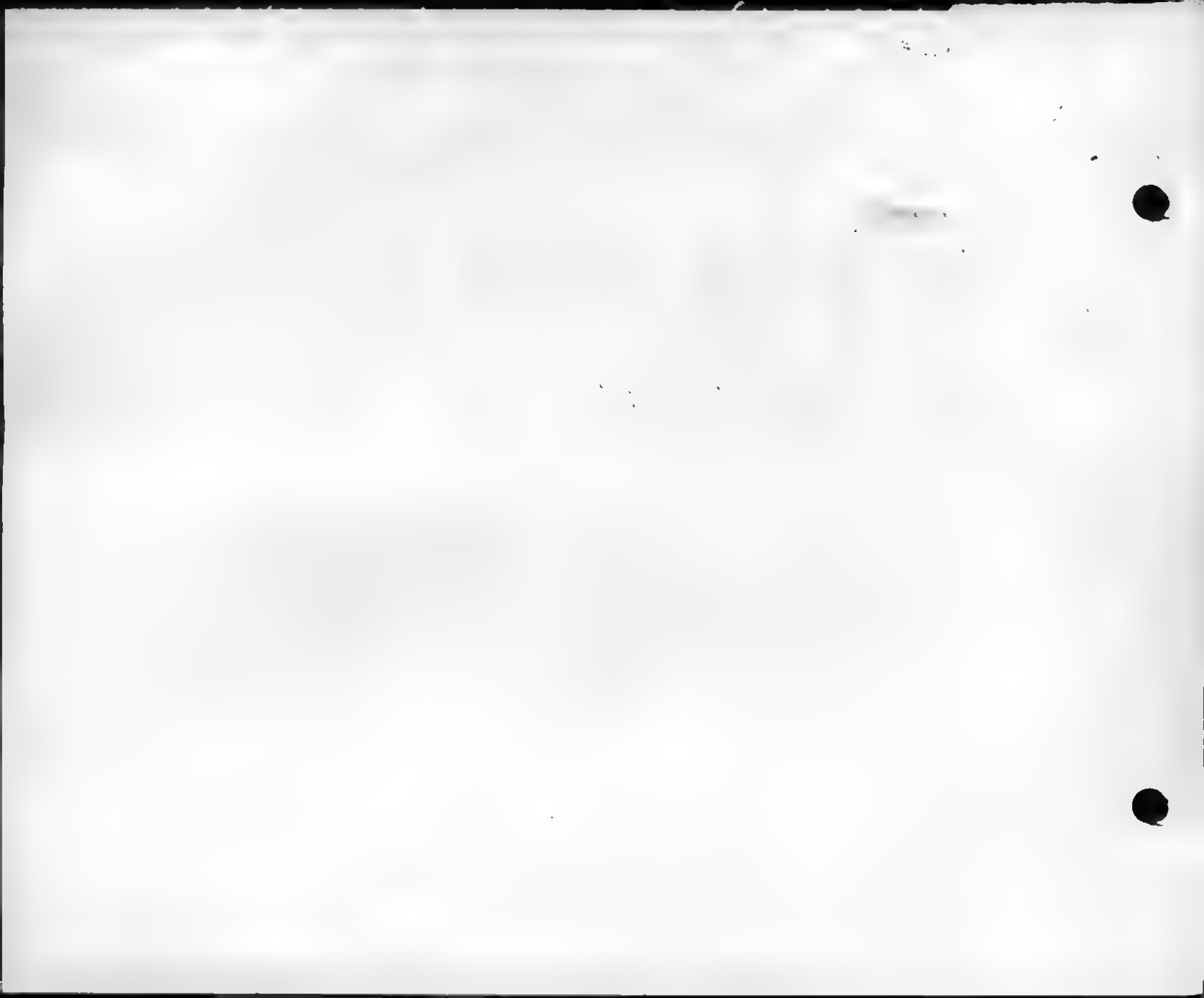
VR A-1 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16456

16467

1. DECEASED-NAME (Type or print) First Middle Last GRACE M WILKINSON			2a. DATE OF DEATH Month Day Year 11 1 68			2b. HOUR 280 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2-13-86		6. AGE (In years last birthday) 82 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pineview Garden		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House wife		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md		13b. COUNTY Pr. George		13c. CITY OR TOWN Brandywine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER RT 1 BOX 293		14. FATHER'S NAME First Middle Last David Thomas Young		15. MOTHER'S MAIDEN NAME First Middle Last ANNA F WATSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO 24-36-2849		17. INFORMANT Harold F WilkinSON		Address BRANDYWINE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> 109 DUE TO, OR AS A CONSEQUENCE OF <u>due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Alfred R. Lapin		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 11-1-68			
22d. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN		22e. ADDRESS CLINTON, MD					
23a. BURIAL, CREMATION, or other disposal Burial		23b. DATE Nov 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Immanuel McChesnut		23d. LOCATION (City or Town) (County) (State) Clinton Md	
24. FUNERAL DIRECTOR Hunt Funeral Home, Halloway, Md.		25a. REC'D BY REGISTRAR DATE NOV 6 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



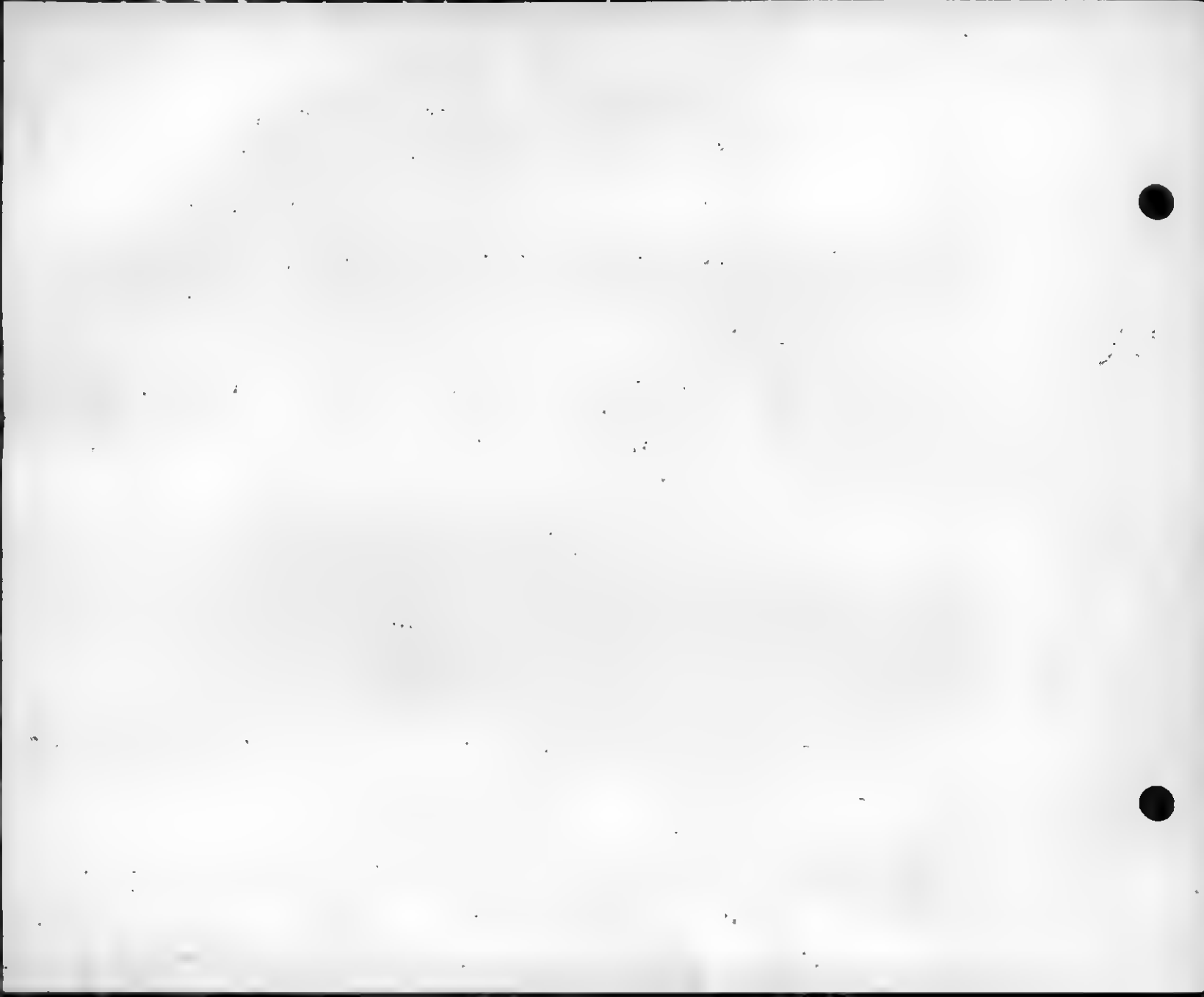
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A 15
30M REV

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR 11/45P M			
ARTHUR LAWRENCE WILLIAMS						Nov 22, 1968						
3. SEX male		4. RACE white		5. DATE OF BIRTH March 14, 1905			6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Va		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md						
10. CITY OR TOWN OF DEATH Cheverly, Md			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Heating Engineer			12b. KIND OF BUSINESS OR INDUSTRY D C Government			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md			13b. COUNTY Pro Geo		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7013 Riverdale Road			
14. FATHER'S NAME First Middle Last William H Williams				15. MOTHER'S MAIDEN NAME First Middle Last Bessie Goodman								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 214 03 0493		17. INFORMANT Lucille M Williams			Address Lanham, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> <u>100X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis to Pelvis &</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rupture</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>11-16</u> , 19 <u>68</u> , to <u>11-22</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-22</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>A Deitz</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>11/23/68</u>						
22d. PHYSICIAN'S NAME (Type) A Deitz		22e. ADDRESS Pro Georges Plaza Hyattsville, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 26, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 27 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 5 may be retained for your files.

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16456

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16469

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 11-14-68 19:30am			2b HOUR		
Virgil Joseph Williams											
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR		
Male	White	10-24-1909	59 YRS			11 14 68			11:20am		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Virginia			U S A						Prince George's Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital								
13a USGA. RESIDENCE (Where deceased lived, if institution Residence before coming to STATE)			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER		
Maryland			Prince George's Gambrills			YES <input type="checkbox"/> NO <input type="checkbox"/>			Rt. 3		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Elbert M Williams			Dora Millsap								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
no			220-05-6119			Mattie F. Williams - same as #13 above					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of chest											
750 X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
750											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR AM			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			9:30am 11-14-68			Shot self at home					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory office building, etc)			21f LOCATION Street or RFD No			City or Town County State		
			home			same as #13					
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED		
John Kehoe MD			John Kehoe MD						11-15-68		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			11/18/68			Hillcrest Cemetery			Annapolis		
24 FUNERAL DIRECTOR (Name, Address, and Phone)						25a REC'D BY REG STR			25b REGISTRAR'S SIGNATURE		
HOPPING FUNERAL HOME						NOV 18 1968					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

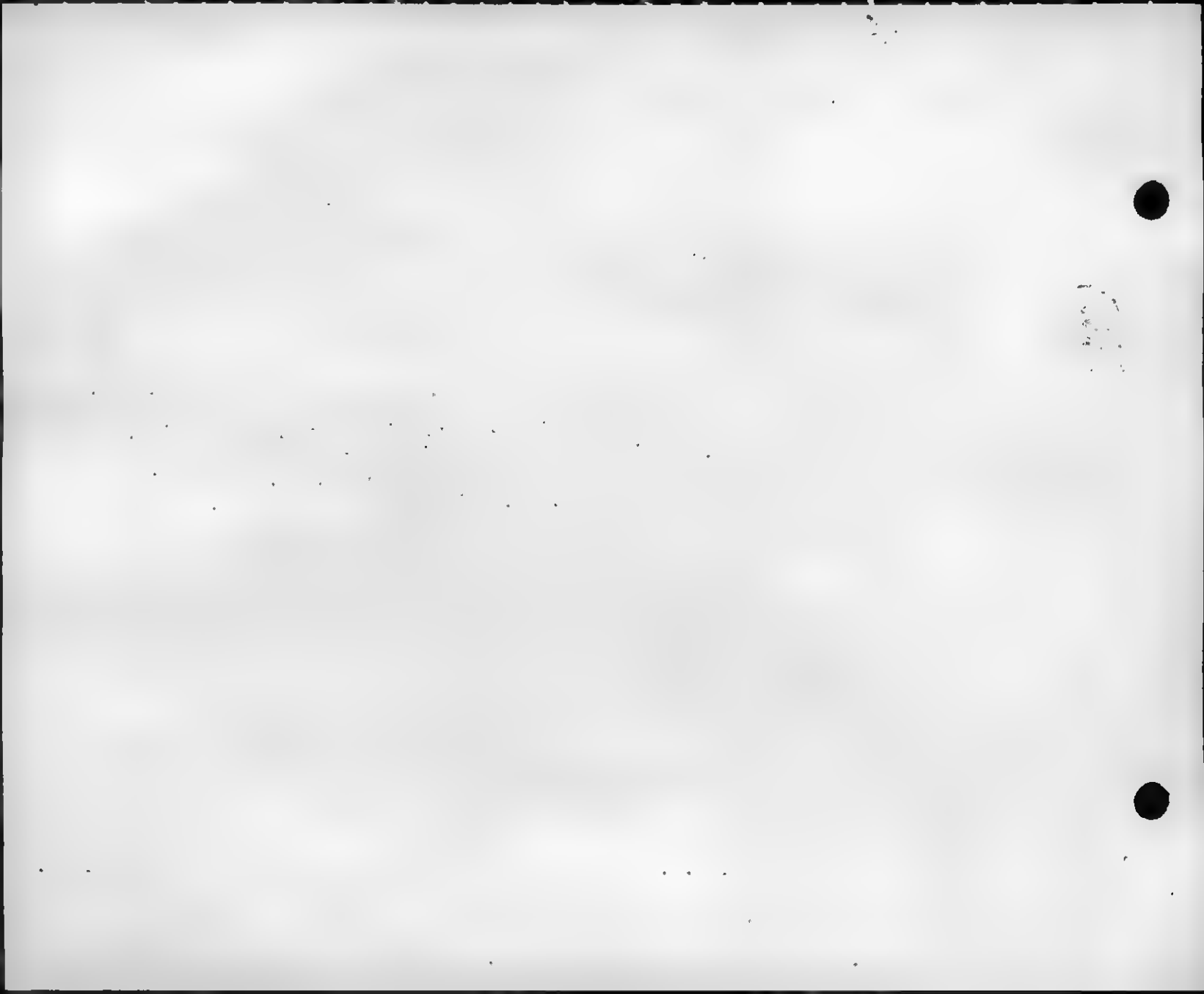
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16457

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16457

1. DECEASED NAME (Type or print) First Middle Last Sydney T. Willits			2a. DATE OF DEATH Month Day Year Nov. 26, 1968		2b. HOUR P. M. 10:15
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH 5/11/06		6. AGE (In years last birthday) 62 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Md	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md		
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's General		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Plumber	12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Prince George's	13c. CITY OR TOWN Glenn Dale	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Box 204	
14. FATHER'S NAME First Middle Last David Willits			15. MOTHER'S MAIDEN NAME First Middle Last Lizzie Lallie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 577-07-8908	17. INFORMANT Address Johanne G. Reynolds Glenn Dale, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2. Malignant lymphoma involving stomach, and duodenum and pancreas. DUE TO, OR AS A CONSEQUENCE OF (b) duodenal ulcer. DUE TO, OR AS A CONSEQUENCE OF (c) 4. Cirrhosis of the liver. Bilateral massive pulmonary embolism. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 02					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 2 - 16 , 19 50 , to 11-26 , 19 68 , that (I) (we) last saw the deceased alive on 11-26 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. Deitz				22c. DATE SIGNED 11-26-68	
22d. PHYSICIAN'S NAME (Type) Aaron Deitz, M.D.				22e. ADDRESS Prince George's Plaza, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov 30, 1968	23c. NAME OF CEMETERY OR CREMATORY Northeast Cemetery		23d. LOCATION (City or Town) (County) (State) Northeast Cecil Md	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DEC 2 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge					

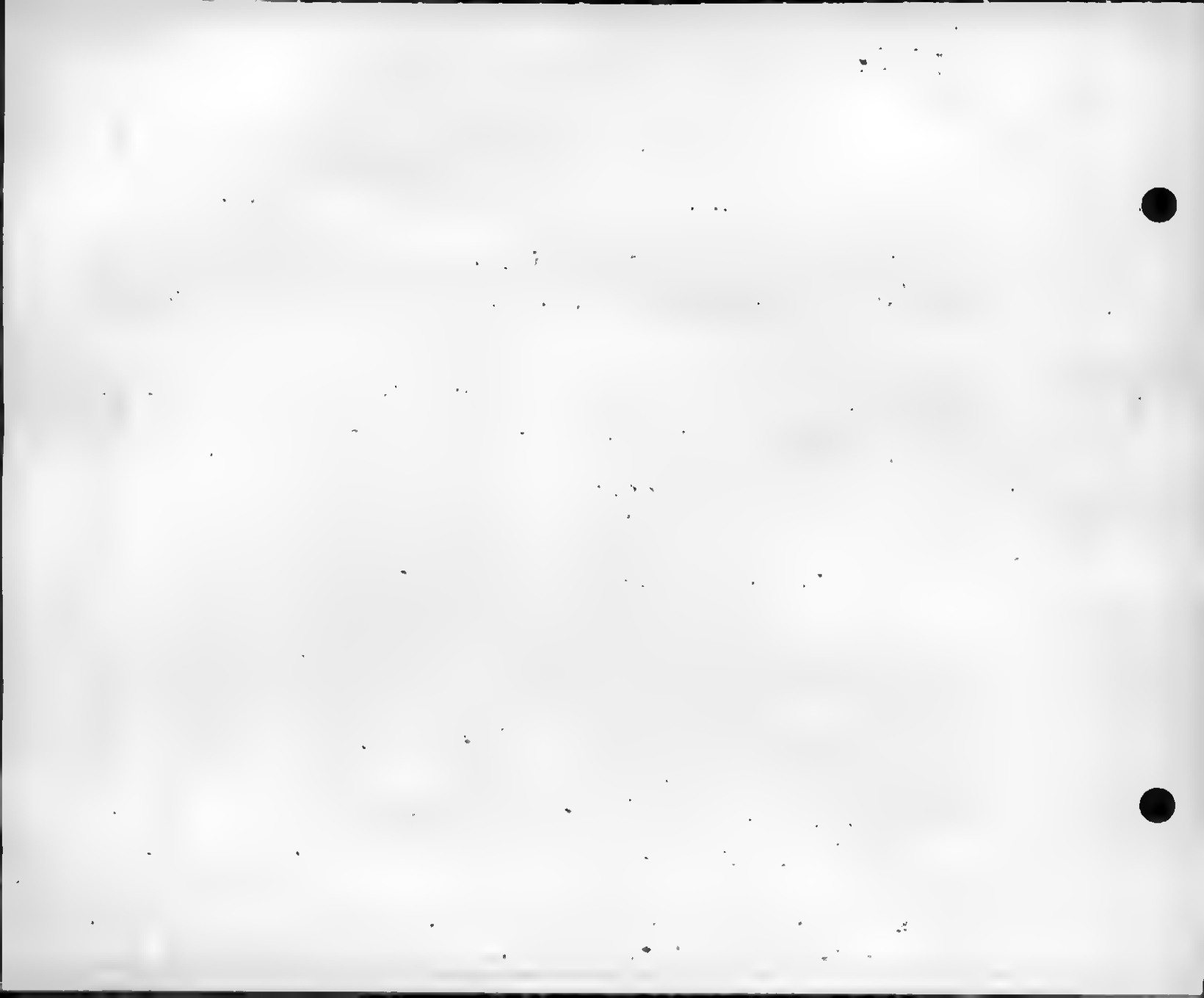


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Examiner - X - Verner A. Albers, M.D.

<div>16458</div> <div>Maryland State Department of Health</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 5 Film G L07 11w 12/6/68</div> <div>CERTIFICATE OF DEATH</div> <div>1647</div>											
1. DECEASED NAME (Type or print) First Middle Last James A Wilson						2a. DATE OF DEATH Month Day Year 11 23 68			2b. HOUR AM PM 9:55 AM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 2/9/89 2/9/89		6. AGE (in years last birthday) 80 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges County Md					
10. CITY OR TOWN OF DEATH Riverdale			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Clerk - Railway Express Co			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. CITY OR TOWN Prince Georges College Park		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 4904 Ruatan Street				
14. FATHER'S NAME First Middle Last ?				15. MOTHER'S MAIDEN NAME First Middle Last ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no				16b. SOCIAL SECURITY NO. 577 18 9394A		17. INFORMANT Address Charlotte Collins College Park, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>ASEVD - Coma</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <u>Prostatic hypertrophy</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/22</u> , 19 <u>68</u> , to <u>4/23</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>4/23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <u>(did not)</u> view the body after death.											
22b. SIGNATURE <u>Verner A. Albers, M.D.</u>				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) Verner A. Albers				22e. ADDRESS 4404 Queensbury Rd., Riverdale							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 27, 1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Wheaton Montgomery, Md.					
24. FUNERAL DIRECTOR P. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE DEC 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Certificate signed with concurrence of Dr. John Kehoe, Deputy Medical Examiner

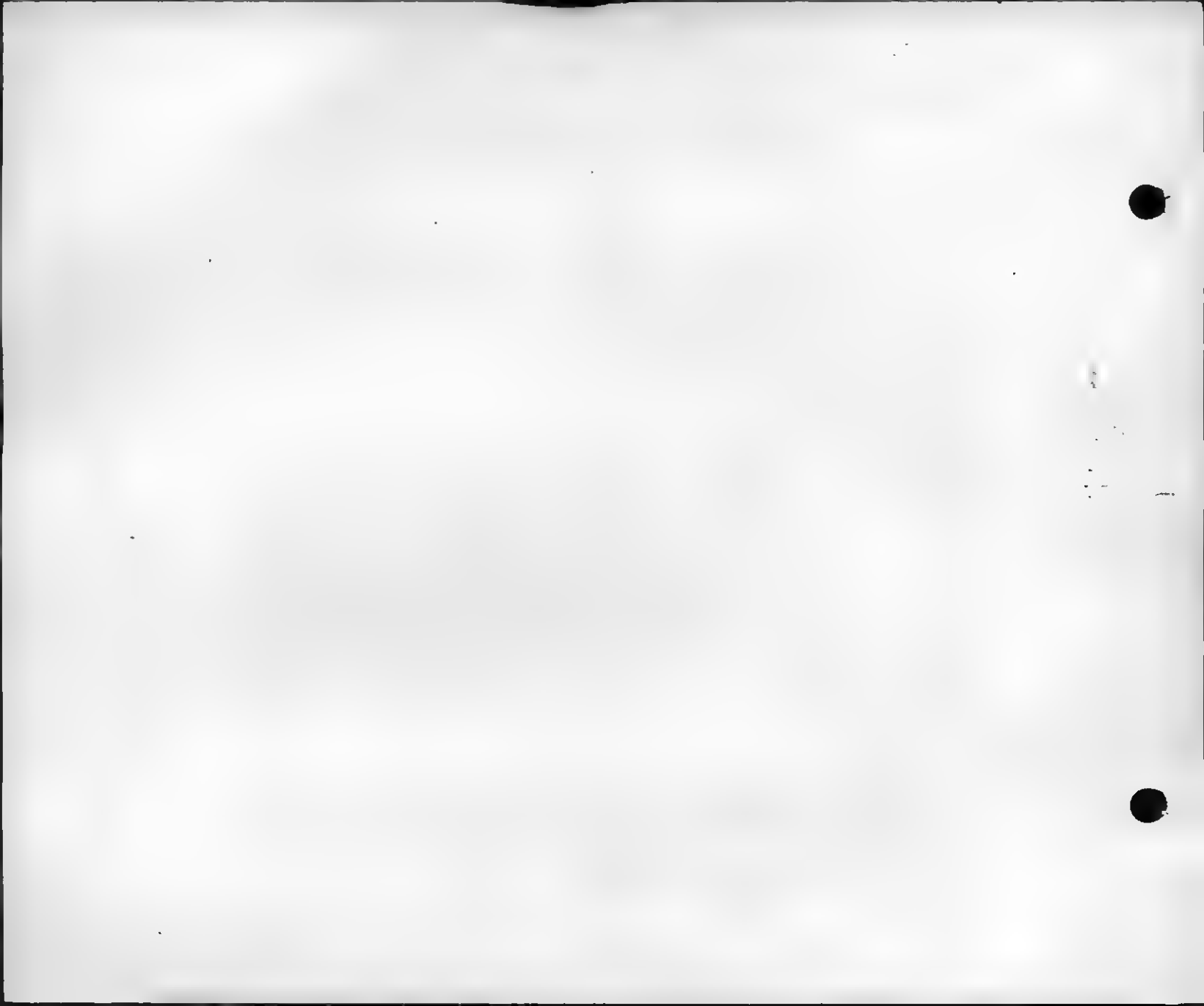
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16459

CERTIFICATE OF DEATH

16472

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> , MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>226 Audrey Lane, Apt. 302</u>				d. STREET ADDRESS <u>226 Audrey Lane, Apt. 302</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Richard</u> First <u>Moran</u> Middle <u>WELL</u> Last <u>WOOD</u>				4 DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>1968</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>August 11, 1915</u>	9 AGE (In years lost birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cherrydale, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. of Am.</u>	
13. FATHER'S NAME <u>Lilton Wood</u>				14. MOTHER'S MAIDEN NAME <u>Myrtie Walker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Navy May 24 to Oct. 1945</u>		16. SOCIAL SECURITY NO <u>578-05-7601</u>		17. INFORMANT <u>wife</u> Address <u>Mrs Pearl Wood - 226 Audrey Lane, Oxon Hill</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>4109 Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerotic Hypertensive Heart Disease 11 years</u> DUE TO (c) <u>Arteriosclerosis Generalized 15 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>3 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus Known for 7 years.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 16</u> , 19 <u>68</u> to <u>November 13</u> , 19 <u>68</u> , that (I) (was) last saw the deceased alive on <u>October 29</u> , 19 <u>68</u> , and that death occurred at <u>6:00</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Walcutt W. Gibson</u> M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED <u>November 13, 1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>Walcutt W. GIBSON</u>				22d. ADDRESS <u>4300 St. Barnabas Road Marlow Heights, Md. 20031</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>11-18-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Natl. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Wilhelm Funeral Home 433 Rutland Pa. Sullivan</u>				25a. REC'D BY REGISTRAR <u>NOV 20 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16460

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1647

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 11-30-68 12:32pm M		2b HOUR	
Robert		Edward		Yeszerski							
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR MONTHS	8 UNDER 24 HRS DAYS	9 UNDER 24 HRS HOURS	10 UNDER 24 HRS MIN	2c DATE PRONOUNCED DEAD Month 11 Day 30 Year 68 12:41pm M		2d HOUR	
Male	White	10-21-1945	23 YRS								
7a BIRTHPLACE (State or foreign country)		7b CIT ZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Alabama		U S A				Prince George's				Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
Cheverly		Prince George Hospital		Policeman							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY - MTS?		13e STREET AND NUMBER			
Maryland		Prince George's		Landover		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1954 Bright seat Road			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
Edward Yeszerski								Chella Culpepper			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT		ADDRESS					
(If yes give war or dates of service)		unknown		Veronica K. Yeszerski		1954 Brightseat Rd.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple gunshot wounds of head and chest 165X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 2:30pm 11-30-19 68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		Shot by assailant					
21d INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street factory, office building, etc.)		21f LOCATION Street or RFD No		City or Town		County		State	
		7000 Block of Greig Street, Seat Pleasant, Prince George Co., Md.									
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b. DATE SIGNED							
		John Kehoe MD Riverdale, Md.		12-1-68							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		12-4-68		Cedar Hill Cemetery		Suitland		Pr. Geo.		Md.	
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Wilhem Funeral Home		4308 Suitland Rd. S. E.		DEC 9 1968							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16461

CERTIFICATE OF DEATH

16475

1 DECEASED NAME (Type or print) Floyd E. Yocum Sr.		First Middle Last		2a. DATE OF DEATH Month Day Year 11 15 68		2b. HOUR 8:15 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 2/14/1898		6. AGE (In years last birthday) 70 YRS.	
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pr. Geo. Md.	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Magnolia Gardens Nur.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 9259 Limestone Pl.		14. FATHER'S NAME First Middle Last John E. Yocum		15. MOTHER'S MAIDEN NAME First Middle Last Cora Sabin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	
16b. SOCIAL SECURITY NO		17. INFORMANT Mrs. Betty V. Gaier		Address 3417-Duke St., College Park, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>pulmonary emboli</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes Mellitus & Pyelonephritis & uremia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1967</u> to <u>Nov 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>11/15/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <u>Leon R. Hewitsky</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/15/68	
22d. PHYSICIAN'S NAME (Type) Leon R. Hewitsky		22e. ADDRESS 3408 Rhode ISland Ave NE, Rainier					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 11/19/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Valley's Funeral Home Inc.		ADDRESS Mt. Rainier Maryland		25a. RECORD BY REGISTRAR DATE NOV 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16462

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16476

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 11-30-68 191:02am				2b. HOUR	
Arleigh			L		Young						
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year 11 30 68 191:15am		
Male	White	2-28-1929		39 YRS.							
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.				
Georgia			U.S.A.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Non-Em. Officer			U.S.A. 2.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE						13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER	
Maryland						Prince George's Suitland				Andrews Air Force Base	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Lee					Young	Mehon Connolly					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			
Yes			254-38-5515		Lee Young Rt. 7			Fitzgerald Ga.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of brain</u> <u>8120</u> DUE TO, OR AS A CONSEQUENCE OF <u>Trauma - auto accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>8164</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>1:00am 11-30- 19 68</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Driver of car involved in collision.</u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Brook Drive and Penna. Ave. Prince George County, Maryland</u>			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
<u>John Kehoe MD</u>			Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			12-1-68		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial			12-5-68		Anderson Cemetery		Anderson South Carolina				
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
w-w. Chamber Co. 517-11						St. A.E.		DEC 5 1968		J. Charles Judge	

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10M REV. 1/68

F. Gasch's Sons Hyattsville, Md.

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